**Needs Assessment Form**

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| **Personal Information** | | | | | |
| Name: |  | **Address:** |  | | |
| Telephone No: |  |
| Date of Birth: |  |
| Ethnicity: |  |
| Language: |  | *Next of Kin contact details:* |  | | |
| Next of Kin: |  |
| EMIS No: |  |
| Azeus No: |  |
| Is a translator required? | | **Yes** |  | **No** |  |

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| **Assessment Details** | |
| Responsible Assessor: |  |
| Assessment Type: |  |
| Responsible Team: |  |
| Single or joint: |  |
| Date & Time of Assessment: |  |
| Please provide details: |  |

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| **Consent** | | | | | | | | |
| Is the adult considered to have Mental Capacity to consent to this assessment? | | | | **Yes** |  | | **No** |  |
| If not possible to gain written consent, has the person verbally consented to this assessment? | | | | **Yes** |  | | **No** |  |
| Please record date and time verbal consent provided: | | | | **Yes** |  | | **No** |  |
| *If it is considered the person LACKS capacity to consent to the assessment process please complete and document the Mental Capacity Assessment and Best Interest Decision making process.* | | | | | | | | |
| Has consent for the assessment process been made on a Best Interest basis? | | | | **Yes** |  | | **No** |  |
| Please provide details: | | | | | | | | |
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| **Referral Information** | | | | | | | | |
| Name of referrer: |  | | | | | | | |
| Role / Relationship: |  | | | | | | | |
| Team: |  | | | | | | | |
| Contact information: |  | | | | | | | |
| Reason for referral: |  | | | | | | | |
| **Part A: About You** | | | | | | | | |
| Tell us about yourself and the things you are seeking to do or change. Following this assessment process, the team responsible for this assessment process will consider your personal situation, and assist to enable you to maintain and improve your wellbeing. What do you think your needs are?  *Professional note: If the adult is unable to provide the information independently please detail who has provided the information.* | | | | | | | | |
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| **Important Others** | | | | | | | | |
| This part of the form is about who is important to you and who helps support you to maintain your wellbeing, for example;  Family members or friends;  Neighbours or people from your local community;  Professionals (e.g. doctors, Community Support Team, counsellors);  Paid supporters (e.g. cleaners or gardeners). | | | | | | | | |
| **Who is important to me:** | | **Their role, or relationship to me:** | **Why they are important to me:** | | | **How they support me:** | | |
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| Is there anybody else present during this assessment? | | | | **Yes** |  | | **No** |  |
| *If yes, please give their name and the nature of your relationship with the person:* | | | |  | | | | |
| Does the person consent to their presence? | | | | **Yes** |  | | **No** |  |
| Does the person consent to the contribution? | | | | **Yes** |  | | **No** |  |

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| **Health Information** | | | | |
| Tell us about any physical or mental health conditions you have and how you manage these: | | | | |
| ***Professional use only:***  Please include information regarding sensory/ communication needs | | | | |
| Tell us about your medication and how you manage this: | | | | |
|  | | | | |
| Do you require assistance to collect, remember or to take your medication? | **Yes** |  | **No** |  |
| Do you have any allergies?  *If yes, please describe them:* | **Yes** |  | **No** |  |
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| Do you experience any difficulties with your mobility?  *Please tell us more about this, including any equipment you may use:* | **Yes** |  | **No** |  |
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| **Care and Support** |
| This section enables you to tell us what you are able to do, and what you want to achieve. We will look at this with you during the assessment.  *Assessor: Add to the sections below giving your professional recommendations and actions. Give evidence of alternatives that have been considered for all unresolved needs.* |
| **Eating, drinking and maintaining a good diet** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unmet |
| ***Professional use only:*** |
| **Maintaining personal hygiene** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unresolved |
| ***Professional recommendation:*** |
| **Being appropriately clothed** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unresolved |
| ***Professional recommendation:*** |
| **Managing toilet needs** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unresolved |
| ***Professional recommendation:*** |
| **Being able to make use of the home safely** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unresolved |
| ***Professional recommendation:*** |
| **Maintaining a habitable home environment** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unresolved |
| ***Professional recommendation:*** |
| **Developing and maintaining family or other personal relationships** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unresolved |
| ***Professional recommendation:*** |
| **Accessing and engaging in work, training, education or volunteering** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unresolved |
| ***Professional recommendation:*** |
| **Making use of necessary facilities or services in the local community** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unresolved |
| ***Professional recommendation:*** |
| **Carrying out any caring responsibilities the adult has for a child** |
| Desired outcome: |
| Early Help / Community options discussed: |
| Met by community resource Met by carer Unresolved |
| ***Professional recommendation:*** |
| **Document anything not captured elsewhere on this assessment** |
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| **Part B: Assessor to Complete** | | | | | | | |
| Identifying a Carer | | | | | | | |
| Is there a Carer? | | **Yes** |  | **No** | | |  |
| Has the Carer been informed of their right to an assessment? | | **Yes** |  | **No** | | |  |
| Does the Carer want a separate assessment? | | **Yes** |  | **No** | | |  |
| If the Carer was NOT informed of their right to an assessment, give the reason: | |  | | | | | |
| If the Carer does not want an assessment, give their reasons: | |  | | | | | |
| Carer’s Personal Details | | | | | | | |
| Name: |  | Address: | |  | | | |
| Phone Number: |  |
| Date of Birth: |  |
| Relationship to the Cared For person: |  |
| EMIS No: |  |
| Azeus No: |  |
| Ethnicity: |  |
| Language: |  |
| Is a translator required? | | **Yes** | |  | **No** |  | |

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| **Eligibility** | | | | |
| *Person’s eligibility*: The threshold is based on identifying how a person’s needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing. Indicate below that the person meets the following criteria: | | | | |
| **Condition One:** The adults needs arise from, or are related to, a physical or mental impairment or illness | | |  | |
| **Condition Two:** As a result of the person’s needs the adult is unable to achieve two or more of the above specified outcomes | | |  | |
| **Condition Three:** As a consequence of being unable to achieve these outcomes there is an overall significant impact on their wellbeing | | |  | |
| **Eligibility Summary** | | | | |
| **Please summarise the outcomes the individual would like to achieve and identify unmet needs unable to achieved within the persons existing support network.**  **Consider additional risk factors e.g. night time care requirements; falls risks**  *Consider whether the adult would benefit from the provision of prevention services; information and advice or anything which might be available in the community. Remember* ***Prevent, Reduce, Delay*** | | | | |
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| **Agreed Actions** | | | | |
| **Action** | **Team / Worker Responsible** | | | **Date Achieved** |
|  |  | | |  |
| **Signatures** | | | | |
| **Person’s signature** | | | | |
| **Declaration**  In signing this form, I agree that it is an honest view of my current situation, the support I need and the support I am getting now from family, friends and other people. I understand that personal information gathered about me, and the care arrangements that arise from it, may need to be shared with other departments and that this departments may hold both paper and electronic records. | | | | |
| Signature: | | Date: | | |
| Print name: | | | | |
| **Representative’s signature** | | | | |
| **Declaration**  In signing this form, I agree that it is an honest view of the person’s current situation, the support they need and the support they are getting now from family, friends and other people. I understand that personal information gathered, and the care arrangements that arise from it, may need to be shared with other departments and that those departments may hold both paper and electronic records. | | | | |
| Signature: | | Date: | | |
| Print name: | | | | |
| **Assessor’s signature** | | | | |
| **Declaration**  In signing this form, I agree that this is a true reflection of the person’s current situation. | | | | |
| Signature: | | Date: | | |
| Print name: | | | | |