



QUALITY LIFESTYLE ALLIANCE INC.

SERVICE USER ASSESSMENT FORM

Type of Funding []

Hours Per Week []

Sleepovers Yes [] or No []

Date of Assessment: Assessed By:

SECTION 1: SERVICE USER DETAILS

Name:

Date of Birth: Age:..... Gender: [] F [] M

Address:.....

Country and Place of Birth:

Telephone HomeMobile.....

Email

Understanding of English: [] Very well [] Well [] Not Well

Speaking of English: [] Very well [] Well [] Not Well

Language:

Aboriginality: [] Aboriginal [] Torres Strait Islander [] Non Aboriginal

Living Arrangements:

Marital Status [] Single [] Married [] De Facto

Does the Service User live alone? [] Yes [] No

Housing Type:

Income: [] Disability [] Mobility Allowance [] Other

Public Trustee: [] Yes [] No

Identified skills/knowledge/attributes:

Psycho-social needs:

Cultural Needs

Service User's View of Their Situation:

Family View: (Is a carer available

Next of Kin _____

Next of Kin Contact Details

CONTACTS	Name	Relationship	Address	Phone
Main Carer:				
Other Carer:				
Advocate:				
Doctor:				

SECTION 2: REFERRAL DETAILS

Referred by:

Reason for Referral:

SECTION 3: ASSESSMENT OF SERVICE USER NEEDS

Known Health Problems:

Medications:

Nil

Does the Service User require supervision when taking medications?

Yes No

Aids Currently Used:

-
-
-
-

Further Aids Required: (Check the bathroom, access and other areas of the home)

-
-
-

Aids organised? Yes No

VISION	HEARING	ORAL	DIET
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Own teeth	<input type="checkbox"/> Diabetic
<input type="checkbox"/> Glasses	<input type="checkbox"/> Aids	<input type="checkbox"/> Dentures	<input type="checkbox"/> Soft
<input type="checkbox"/> Impaired	<input type="checkbox"/> Mild loss		<input type="checkbox"/> Normal
<input type="checkbox"/> Blind	<input type="checkbox"/> Severe loss		<input type="checkbox"/> Special (specify)_____

ACTIVITIES OF DAILY LIVING <i>Tick as appropriate</i>						
	Unable to perform task	Substantial help required	Moderate help required	Minimal help required	Fully independent	Date Reviewed
Personal hygiene						
Bathing						
Feeding						
Toileting						
Dressing						
Shopping						
Wheelchair*						
Chair/bed transfers						

* Score only if Service User is unable to ambulate and is trained in wheelchair management.

MENTAL STATE Fully alert Sometimes confused
 At risk due to mental state
 Confused but safe

Note any concerns: _____

INDEPENDENT LIVING	Done by Self	Done by Family	Requires Assistance
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Banking & Finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minor Home Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INTERESTS

Interested in: Picnics, outings, etc. Residential Host Family No Respite

FURTHER COMMENTS ON NEEDS OF SERVICE USER – (eg safety of housing):

SECTION 4: OUTCOME OF ASSESSMENT

Request for Medical Information Yes No Referral for Case Discussion Yes No

HAS CONSENT BEEN OBTAINED TO SEEK FURTHER INFORMATION OR TO DISCUSS SERVICE USER WITH OTHER AGENCIES? Yes No
(Attach form with Service User signature)

Goals for this Service User: See Management Plan

Services to be Provided: See Roster

OTHER ACTION/REFERRALS: See Action Plan

SECTION 5: ASSESSMENT FOR PREPARATION OF MEALS

- 1. Physically unable to prepare meals? Yes No (can the OT help?)
- 2. Danger to self in preparing meals? Yes No
- 3. Does not have the physical means to cook? Yes No (can this be addressed?)
- 4. Would a shopping service assist? Yes No (arrange regular shopping?)
- 5. Is there self neglect or abuse? Yes No
- 6. Is the Service User eating well? Yes No
- 7. Is this a vital service to assist the carer? Yes No

10. Special requirements:.....
.....

Service User copy of Care Plan completed

_____ Date

.....
Signature of Assessor

.....
Name and Position of Assessor

.....
Date

To provide quality care for you we may need to consult with a team of skilled people and may require your consent. If you are willing to give your consent, please sign the section below:-

SERVICE USER'S CONSENT AND SIGNATURE

I, _____ (print name)

Address: _____

_____ State _____ Post Code _____

Verbal consent given Date: ____/____/2____

Verified by: _____

Consent to information about me being made available as follows:

	<u>Information can be obtained from</u>	<u>Information can be provided to:</u>
Medical Officer in relation to my support requirements only	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability Services Queensland as it applies to my funding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Manager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coordinators	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relevant information may be shared with other team members involved in my care but ensuring confidentiality guidelines are not breached.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Service User's / carer's signature) _____

ASSESSOR CHECKLIST

Service User / Carer has been informed of/provided with:

- The purpose of the assessment.
- Their rights and responsibilities.
- The complaints process.
- Proposed actions, including referrals and has agreed to them.
- A copy of this care plan.
- A copy of "Information on our Service"

Name of Assessor:

Signature: Date:

Quality Lifestyle Alliance Inc. respects the choice of the Service User and will abide by these choices. _____ has requested that no formal support plan be formulated for his/her support needs.

Signed _____ Service User

Witnessed _____ QLA Representative

Date ____/____/2____

Action Plan

Actions required by QLA Staff

Actions taken by QLA Staff

Completed? Yes No

Completion Date _____