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| **Community Occupational Therapy Services**  **Gwasanaethau Therapi Galwedigaethol yn y Gymuned** |

**Major adaptation memorandum**

To:

Date:

**Please see below details of recommendations for Major Adaptations:**

**Lead OT: ……………………………………… Tel: ……………………..**

**(OT responsible for case following recommendations)**

**Name:**

**Address:**

**Date of Birth:**

**Telephone Number:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***ADAPTATION MONITORING INFORMATION – All required boxes must be completed*** | | | | | | | | |
| 1. ***Date of First Contact \* (Required only for NCC OT recommendations) …………………………………***   ***\*NB: The ‘First Point of Contact’ is the date of the client’s first recorded contact with the local authority, relating specifically to an adaptation, for which DFG is subsequently offered. Alternatively, in the case of an existing client, it is the date on which the need for an adaptation for which DFG is subsequently offered is first raised, either by the client or the Authority.*** | | | | | | | | |
| 1. ***Date the need for adaptation was identified***   ***(This will usually be the assessment date) ….………………………………*** | | | | | | | | |
| 1. ***OT Referral Source: (Please tick which applies)*** | | | | | | | | |
| NCC: OT URGENT |  | NCC: OT NON-URGENT | |  | NCC: OTA URGENT |  | NCC: OTA NON-URGENT |  |
| NCC: OT DFG URGENT |  | NCC: OT DFG NON- URGENT | |  | NCC: OTA DFG URGENT |  | NCC: OT DFG NON-URGENT |  |
| NCC: CHILDREN’S TEAM OT |  | NCC/HB FRAILTY (CRT) | |  | HOSPITAL OT |  | LD OLDER PERSONS MENTAL HEALTH |  |
| MENTAL HEALTH |  | CHC | |  | OTHER ……………………………………………………………………………………. | | | |
| LONG TERM CONDITIONS | | |  |  | | | | |
| 1. ***Urgent Recommendation***   YES / NO | | | | 1. ***Will the work be enabling Hospital discharge?*** YES / NO | | | | |

**Property Owned by:**

**Capacity Issues:** Yes No

(Please circle)

**Details:**

**Social and Physical Environment:-**

**Effects of Disability:-**

**Service User’s Height :**

|  |  |  |
| --- | --- | --- |
| a | facilitating access by the disabled occupant to and from the dwelling |  |
| b | making the dwelling safe for the disabled occupant and other persons residing with him |  |
| c | facilitating access by the disabled occupant to a room used or usable as the principal family room |  |
| d | facilitating access by the disabled occupant to, or providing for the disabled occupant, a room used or usable for sleeping; |  |
| e | facilitating access by the disabled occupant to, or providing for the disabled occupant, a room in which there is a lavatory, or facilitating the use by the disabled occupant of such a facility; |  |
| f | facilitating access by the disabled occupant to, or providing for the disabled occupant, a room in which there is a bath or shower (or both), or facilitating the use by the disabled occupant of such a facility; |  |
| g | facilitating access by the disabled occupant to, or providing for the disabled occupant, a room in which there is a wash hand basin, or facilitating the use by the disabled occupant of such a facility; |  |
| h | facilitating the preparation and cooking of food by the disabled occupant; |  |
| I  J | improving any heating system in the dwelling to meet the needs of the disabled occupant or, if there is no existing heating system there or any such system is unsuitable for use by the disabled occupant, providing a heating system suitable to meet his needs;  facilitating the use by the disabled occupant of a source of power, light or heat by altering the position of one or more means of access to or control of that source or by providing additional means of control; |  |
| K | facilitating access and movement by the disabled occupant around the dwelling in order to enable him to care for a person who is normally resident and is in need of such care |  |
|  |  |  |

**Service User’s Weight :**

**Recommendations deemed necessary and appropriate:Possible solutions to persons current difficulties to be considered by surveyor e.g. stair lift, LAS, ramp**



**Other ideas considered and ruled out and why e.g. inappropriate equipment trialed**

1.

2.

3.

4.

5.

**Any other relevant Information:**

**For Social Housing only:**

Number of bedrooms - ………………………………….

Occupancy - ………………………………………………

**Joint visit needed** Yes No

(Please delete as appropriate)

Signature of Assessor: …………………………………….……….. Date: …………..……..

Print: ……………………….……….…… Designation……………………………………….

Base: …………………………………………………………..…. Tel No: ………………….

Signature of Community OT: …………………………….……….. Date: …………..……..

Print: ……………………………..……… Designation……………………………………….

Base: …………………………………………………………..…. Tel No: …………………