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

**Occupational Therapy Assessment**

**pART 1: PERSONAL DETAILS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Person’s Name:** | |  | | | | | | | | **L.A. No:** | | |  | |
| **Address:** | |  | | | | | | | | | | | | |
| **Date of Birth:** | |  | | | | | | | | **Tel No:** | | |  | |
| **GP:** | |  | | | | | | | | | | | | |
| **NOK/First Contact:** | |  | | | | | | | | | | | | |
| **First Language:** | |  | | | | | **Communication needs:** | | | |  | | | |
| **Is Person Continuing Health Care Funded** | | | | | | | | | **Yes/No** | | | | | |
|  | | | | | | | | | | | | | | |
| **Is an advocate required?** | | | | | **Yes/No** | | **Is an advocate present?** | | | | | | | **Yes/No** |
| **Name and Contact details** | | | |  | | | | | | | | | | |
|  | | | | | | | | | |  | | | | |
| **Does the Person appear to have any Capacity issues relevant to this Assessment?** | | | | | | | | | | **Yes/No** | | | | |
| **If yes, please complete the Community Occupational Therapy Service Capacity Assessment before completing Assessed Needs section in the person’s best interests.** | | | | | | | | | | | | | | |
| **Occupational Therapy Worker Details** | | | | | | | | | | | | | | |
| **Name:** |  | | | | | | | **Telephone:** | | | |  | | |
| **Referral Date:** | | |  | | | **Assessment Date & Time:** | | | | | |  | | |

**As Occupational Therapy Workers, in accordance with the Social Services and Well-Being act 2014, we will work with you to identify your goals and who or what can help you to achieve them.**

**pART 2: Support Network**

**Do other people support you?**

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|  | | | | | |
| **Name & Relationship** | **Contact Details** | **What tasks do they help you with/their role?** | Present at visit | Carer’s Assessment | |
| Offered | Accepted and Form Left/Sent |
|  |  |  | **Yes / No** | **Yes / No** | **Yes / No** |
|  |  |  | **Yes / No** | **Yes / No** | **Yes / No** |
|  |  |  | **Yes / No** | **Yes / No** | **Yes / No** |
|  |  |  | **Yes / No** | **Yes / No** | **Yes / No** |

**PART 3: ASSESSMENT**

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| **Background Information**: Relevant information about your life, medical history, diagnosis, symptoms, conditions, experiences and support network etc. |
|  |
| **Your Perspective**: What is important to you? What matters to you? |
| *Think about self- care, domestic tasks, leisure and access to work.*  *What strengths/capabilities/resources do you have?* |

**PART 4: OUTCOMES AND ACTIONS**

Consider:-

* What you want to achieve?
* What is preventing you from achieving this? Any risks identified?
* How can you best achieve your aim and who/what can help you achieve it?

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| **Occupational Therapy Intervention/Outcome**  **Based on Morriston Occupational Therapy Outcome Measure (MOTOM) 1999** |

Need/Goals

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Need/Goal |  | | | | | |
| Barriers to function |  | | | | | |
| Objectives/  Plan |  | | | | | |
| Outcome/  Evaluation |  | | | | | |
| **MOTOM Scoring** | Pre Intervention Rating |  | Post Intervention  Rating |  | **Outcome Score** |  |

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| --- | --- | --- | --- | --- | --- | --- |
| 2. Need/Goal |  | | | | | |
| Barriers to function |  | | | | | |
| Objectives/  Plan |  | | | | | |
| Outcome/  Evaluation |  | | | | | |
| **MOTOM Scoring** | Pre Intervention Rating |  | Post Intervention  Rating |  | **Outcome Score** |  |

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| --- | --- | --- | --- | --- | --- | --- |
| 3. Need/Goal |  | | | | | |
| Barriers to function |  | | | | | |
| Objectives/  Plan |  | | | | | |
| Outcome/  Evaluation |  | | | | | |
| **MOTOM Scoring** | Pre Intervention Rating |  | Post Intervention  Rating |  | **Outcome Score** |  |

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| --- | --- | --- | --- | --- | --- | --- |
| 4. Need/Goal |  | | | | | |
| Barriers to function |  | | | | | |
| Objectives/  Plan |  | | | | | |
| Outcome/  Evaluation |  | | | | | |
| **MOTOM Scoring** | Pre Intervention Rating |  | Post Intervention  Rating |  | **Outcome Score** |  |

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| --- | --- | --- | --- | --- | --- | --- |
| 5. Need/Goal |  | | | | | |
| Barriers to function |  | | | | | |
| Objectives/  Plan |  | | | | | |
| Outcome/  Evaluation |  | | | | | |
| **MOTOM Scoring** | Pre Intervention Rating |  | Post Intervention  Rating |  | **Outcome Score** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 6. Need/Goal |  | | | | | |
| Barriers to function |  | | | | | |
| Objectives/  Plan |  | | | | | |
| Outcome/  Evaluation |  | | | | | |
| **MOTOM Scoring** | Pre Intervention Rating |  | Post Intervention  Rating |  | **Outcome Score** |  |

**Final Median MOTOM Outcome Score [ ]**

Rating Scale

1 - Unable to carry out activity

2 - Needs maximum assistance to carry out activity

3 - Needs minimum assistance or supervision to carry out activity.

4 - Able to carry out activity independently, but with difficulty or at risk whilst carrying out

activity

5 - Able to carry out activity independently, with or without adaptive devices or

removal/reduction of risk

MOTOM Exception Code: A R U I E T N C D F S (see guidelines)

**PART 5: ELIGIBLE NEEDS**

List the Needs that meet the eligibility criteria in accordance with the Social Services and Well-Being Act 2014.

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| **Have direct payments been offered to the person?** | | | |
| Yes |  | No |  |
| **If no, state reason why** | | | |
|  | | | |

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| --- | --- | --- | --- |
| **Would the person like a copy of their assessment?** | | | |
| Yes |  | No |  |
| **Would they like a copy of their assessment in Welsh?** | | | |
| Yes |  | No |  |

|  |  |
| --- | --- |
| **Authorisation** | |
| **Signed:**  **Print:**  **Occupational Therapist/Social Work Assistant** | **Date:**  **Time:** |
| **Authorisation** | |
| **Signed:**  **Print:**  **Senior Occupational Therapist/Team Manager** | **Date:**  **Time:** |

SIGNATURE SLIP

Name of Person:

Swift ID:

On: (date)

I have received a copy of my assessment, and am/am not in agreement with its contents.

And/or I wish to make the following comments:

I understand that this form or some of the information in it may be shared with other people involved in my care, and that wherever possible; staff will tell me about this. Information may also be taken from this form and used for monitoring and planning purposes.

Signed…………………………………………….. Date: ……...

Print …………………………………………….

Person/Carer

Signed…………………………………………….. Date: ……...

Print……………………………………………..

Occupational Therapist/Social Work Assistant

Signed…………………………………………….. Date: ……...

Print……………………………………………..

Senior Occupational Therapist/Team Manager

**PART 6: CONSENT AND AGREEMENT**

Information recorded during this assessment process may be shared with others involved in your care. This will help them understand your needs and avoid having to repeat some parts of the assessment. I understand that at times sharing of information will be undertaken in the best interests of my care and that consent may not always be necessary.

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| **Consent to Share Information: tick as appropriate** |
| ( ) I understand that the information collected in this assessment process will be used to  provide care for me. I agree that it may be shared with other health and social care  professionals, including GPs and appropriate voluntary organisations, in order to  provide care for me. |
| ( ) I understand the above; but there is specific personal information that I do not want  information to be shared with. Please give details below. |
| ( ) The person is unable to give consent; e.g. unable to sign. Please give details below. |
| ( ) Person does not give consent |
| Details: |
| Does person want relatives informed of assessment / condition / treatment ? Y ( )N ( )  If yes, person authorised to receive information:  Name: .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. Relationship: .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. ..  Name: .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. Relationship: .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. |
| Name of person: Signature of person: |
| Date: |