# BLUE FORM

## Assisted Living
## Resident's Assessment Form

*(for completion by the resident's doctor, and review every 6 months, see Form 2A)*

**Form 2**
*Schedule to Form 1*
**Resident's Details**

Resident's Name:

Date of Birth: Gender: Male / Female

Address of 52 Chalk Street, Wooloowin, QLD 4030

Supported Residential Service: Willow House

*Tick the column which describes the resident's needs in each area*

| Activity | No Assistance Required | Individual Prompting & Supervision | Physical Assistance Required | Details / Comments |
|---|---|---|---|---|
| **1 Health Needs** | | | | |
| **Cognition & Perception** | | | | |
| * orientation | ☐ | ☐ | ☐ | |
| * memory | ☐ | ☐ | ☐ | |
| * wandering | ☐ | ☐ | ☐ | |
| * personal safety<br>*(use household appliances / emergency response / stranger treatment)* | ☐ | ☐ | ☐ | |
| **Health Issues** | | | | |
| * taking medication | ☐ | ☐ | ☐ | |
| * other regular health needs<br>*(diabetics, wound dressings, nebuliser, epilepsy)* | ☐ | ☐ | ☐ | |
| * personal injury<br>*(ability to attend to minor first aid and/or seek assistance)* | ☐ | ☐ | ☐ | |
| * medical<br>*(ability to recognise need for medical intervention and initiate assistance)* | ☐ | ☐ | ☐ | |
| **Night Support** | | | | |
| * safe practices<br>*(turning off appliances, lock premises, emergency responses)* | ☐ | ☐ | ☐ | |
| * sleeping patterns<br>*(go to bed sleep through night)* | ☐ | ☐ | ☐ | |
| * physical supports<br>*(continence etc)* | ☐ | ☐ | ☐ | |
| * behavioural issues<br>*(requires staff prompting supervision to limit impact)* | ☐ | ☐ | ☐ | |

| **Behaviour Support** | (Pls Circle) | Comments |
|---|---|---|
| * behaviour issues | yes / no | |
| * absconding/wandering | yes / no | |
| * aggressive towards others | yes / no | |
| * self injury | yes / no | |
| * physically assaultive towards others | yes / no | |
| * other behavioural issues<br>*(describe)* | | |

| Activity | No Assistance Required | Individual Prompting & Supervision | Physical Assistance Required | Details / Comments |
|---|---|---|---|---|

## 2 Daily Living Activities *(2.1 of Quality of Care Principles of 1997)*

**Personal Hygiene**

| | | | | |
|---|---|---|---|---|
| * bathing / showering | | | | |
| * grooming | | | | |
| * personal hygiene *(teeth cleaning, shaving)* | | | | |

**Continence**

| | | | | |
|---|---|---|---|---|
| * managing continence | | | | |
| * toileting | | | | |
| * continence aids | | | | |

**Eating**

| | | | | |
|---|---|---|---|---|
| * eating | | | | |
| * eating aids | | | | |

**Dressing**

| | | | | |
|---|---|---|---|---|
| * dressing | | | | |
| * undressing | | | | |
| * dressing aids | | | | |

**Mobility**

| | | | | |
|---|---|---|---|---|
| * ambulation *(walking)* | | | | |
| * transfers *(moving between sitting / standing / lying)* | | | | |
| * negotiating stairs | | | | |
| * mobility aids *(wheelchair / frame / cane)* | | | | |
| * use of safety devices *(eg: handrails)* | | | | |
| * use of transport | | | | |

**Communication**

| | Pls Circle Appropriate Assessment | | | | |
|---|---|---|---|---|---|
| * speech | coherent | slurred | aphastic | communication aid | requires assistance to maintain aids |
| * hearing | no loss | aid | deafness | requires assistance to maintain aids | |
| * eyesight | good | glasses | failing | blind | requires assistance to maintain aids |
| * recognition | family | friends | unresponsive | | |

| | No Assistance Required | Individual Prompting & | Physical Assistance | Details / Comments |
|---|---|---|---|---|
| * general communication needs *(ability to express concepts and needs)* | | | | |
| * use of telephone | | | | |
| * reading | | | | |
| * writing | | | | |

| | (Pls Circle) | Comments |
|---|---|---|

## 3 NURSING SERVICES *(3.8 of Quality of Care Principles 997)*

| | | |
|---|---|---|
| * assessment and planning of care by Registered Nurse | yes / no | |
| * management of care carried out by Registered Nurse | yes / no | |
| * nursing services *(eg: pain management, wound management, etc)* | yes / no | |

## 4 Other Comments / Medical Issues

## 5 Paramedical Needs *(eg speech pathologist, physiotherpist, etc)*

| | |
|---|---|
| *I certify that this resident requires continiuous assistance with above assessed care services .* | signed _____<br>name _____<br>provider nos. _____<br>date _____ |

(Note to meet the requirements for services to be GST free, a resident must be assessed as needing, on a continuous basis, either physical assistance or supervision / prompting with one of the services listed under daily living activities (2) or nursing services (3).

Assisted Living
**Resident's Assessment Form**

**Form 2A**
*Schedule to Form 1*
**Update Schedule**

| Review Date | Changes to Previous Assessment in Form 2 | Medical Practitioner's signature |
|---|---|---|
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