The Cube Disability Limited

Service User Care Services Needs Assessment

This assessment is about you and the information you or your representative give us will help to plan the care and support that you need in a way that meets your identified needs. We will treat the information you give us with care and confidential and will only disclose information to the staff providing care to you and Care Quality Commission and the funding authority when they carry out inspection/monitoring visits.

You can decline to answer any questions that you find intrusive, and we will respect your wishes.

Service User's name:

Senior staff member undertaking assessment:

People involved in the Assessment:

Date assessment took place:

Service user/or representative signature:

Staff member's signature:

Client Details information	
Client First name	
surname	
I prefer to be called	
Diagnosis / Disability	
Home Address	
Landline phone number	
Mobile phone number	
Email address	
Date of Birth	
*The following questions are **optional** but would help us in assessing your needs accurately to ensure we provide the appropriate support.*	
Gender *(Male / Female / Transgender)*	
Religion/Culture	
Ethnicity	
Sexual Orientation	
Language preferred to speak	
Interpreter needed	

Next of Kin Details (1)	
Name	
Address	
Home Address	
Landline phone number	
Mobile phone number	
Email address	
Next of Kin Details (2)	
Name	
Address	
Home Address	
Landline phone number	
Mobile phone number	
Email address	
Emergency contact details	
Name	
Address	
Home Address	
Landline phone number	
Mobile phone number	

Email address	
Relationship to Client	
Carer Details	
Name	
Telephone Number	
General Practitioner Details	
Name	
Practice Address	
Telephone	
District Nurse Details	
Name	
Practice Address	
Telephone number	
Name of Social Worker/Funding authority/Self-funding	
Name	
Address	
Home Address	
Landline phone number	
Mobile phone number	
Email address	
Name of Occupational Therapist	
Name	
Address	
Home Address	
Landline phone number	
Mobile phone number	
Power of Attorney **YES / NO**	
Name:	
Address	
Ownership	
Client owned	
Rented	

Housing Association	

Mental Capacity to make day to day decision? YES / NO	
Date of last tetanus jab?	
Consent for photos of your son/daughter to be used for publicity, website and events associated with the Cube Disability service? YES / NO	
Key safe YES / NO	
Do not resuscitate (DNA) in place? YES / NO	
Meals on wheels? YES / NO	
Allergies (incl. medication) YES / NO	

Personal assessment of Activities of Daily living
My background/hobbies/family/friends What are the most important things that the Care staff need to know about me: What aspect of life do I enjoy:

What is important to me: What concerns me about my future:

Likes (e.g. quiet room, personal item / possession) Dislikes – which may lead to anxiety / behaviours (e.g. noises, specific items, needles) Actions which may reduce anxieties: Any additional information:

Communication Needs:
Method of communication: The best way to give information:

The best time to give information: Method of expressing pain (e.g. crying, facial expressions, vocalisations):

Behaviour Management:
Does the service user present or have they previous presented any behaviours: If yes, how are these behaviour presented?
What are the triggers that might link with the behaviours:
Please indicate any strategies that are used in supporting the service user's behaviour de-escalation:

How Do You Manage Your physical needs:
Personal care:

Dressing and undressing:
Bowel and Bladder Control:
Denture/Oral care:
Skin care:
Sleeping routine:
Hair care:
Hearing:

Vision:
Breathing:
Mobility:
What are your spiritual/religious needs:
Mental capacity to make day to day decision:
Nutritional and dietary assessment:
Current weight:
Meal size Small/medium/large:

Particular diet-kosher, vegetarian, polish, British, afro- caribean, other
Food allergies: Yes / No Drink allergies: Yes / No *If yes, please indicate which foods / drinks you have allergies to:*

Food likes	Food dislikes
Difficulties chewing or swallowing food?	

Equipment used in place: Please Tick
Care link pendent:
Hospital bed:
Electric hoist:
Recliner chair:
Shower chair:

Bath board:
Grab rails:
Walking frame:
Walking stick:
Tripod walking stick:
White stick:
Guide dog:
Ceiling pulls:
Slide sheet:
Perching stool:
Toilet seat raiser:
Rotunda:
Trolley walking stick:
Powered chair:
Electric hoist:

Please give information on your Medical condition:
Do you take Medication:
How is the medication taken?

Who administers medication?
Who orders repeat medication prescriptions:

Personal outcomes when attending care provider:	
What I am good at	What I would like to work towards

Please provide any other information you feel is relevant to this assessment:

Permission to share my personal information

I give The Cube Disability service staff permission for them to use the key safe to access my property so they can meet my care needs as identified in my care planning document.

I also give them permission to give me my medication to keep me healthy and safe.

I also give them consent to share my personal information kept at the Cube Disability office with my next of kin, Social Services, Care Quality Commission, and the police.

Client Name:

Client Signature:

Date:

Senior Staff Name:

Senior Staff Signature:

However, if the client is unable to sign due to their disability, their representative/ will sign on their behalf to confirm.