FAR WEST CARER RESPITE CENTRE
NEEDS ASSESSMENT FOR RESPITE CARE

Date of Assessment ______________________

1. CARE RECIPIENT DETAILS

Surname: ______________________________ Other Names: _________________________

Address: ____

Phone number: __________________________ Date of Birth: _________________________

Medicare Number ____________________________ Private Cover _____________________

2. CARERS DETAILS

Surname: ______________________________ Other Names: _________________________

Address: ____

Phone number: __________________________

3. EMERGENCY CONTACTS

Surname ________________________________ Other Names _________________________

Address ________________________________ Relationship _________________________

Business Hours Phone number __________________________

After Hours Phone Number _____________________________

Surname ________________________________ Other Names _________________________

Address ________________________________ Relationship _________________________

Business Hours Phone number __________________________

After Hours Phone Number _____________________________

4. CARE RECIPIENT DETAILS

Primary Disability Chronic illness ☐ Frail aged ☐ Dementia ☐ Disability ☐

Medical Information:

Do you suffer from any of the following conditions, please tick box/s

☐ Allergies	☐ Intellectual disability
☐ Dementia	☐ Asthma
☐ Brain Injury	☐ Terminal Illness
☐ Mental Illness	☐ Cardiovascular
☐ Motor Neurone	☐ Multiple Sclerosis
☐ Osteoarthritis	☐ Paraplegia
☐ Diabetic	☐ Parkinson Disease
☐ Insulin controlled	☐ Osteoporosis
☐ Tablet	☐ Physical Disability
☐ Diet	☐ Emphysema

☐ Epilepsy Seizures yes ☐ No ☐ How often ________________________

Triggers ____

Comments ____

Medication: (Please tick or circle in the appropriate place)

Is medication to be taken during Respite: Yes / No

Medication normally taken: ❑ Independently ❑ Needs assistance

Medication supplied in: ❑ Webster Pack ❑ Dossette Box

ALLERGIES:

____

What occurs ____

Communication: (Please tick the appropriate box)

Able to communicate Yes / No

❑ Verbal ❑ Sentences ❑ Single words ❑ Phrases

❑ Non verbal ❑ Signs ❑ Gestures ❑ Noises

Uses communication to:

❑ Indicate needs ❑ capture attention ❑ Indicate pleasure ❑ Indicate discomfort

Understands:

❑ Sentences ❑ Single words ❑ Gestures ❑ Signs

Can follow:

❑ Simple instruction ❑ Complex instruction

Comments ____

____

____

____

Eating and Drinking: (Please tick appropriate box)

Feeds self ❑ Independently ❑ With assistance

Drinks ❑ Independently ❑ With assistance

Special Diet / Needs ____

____

____

____

____

Sleeping Pattern: (Please tick the appropriate box)

Sleeps:

❑ All night without disturbance ❑ Disturbed sleep but does not wake others

❑ Wakes once or twice during the night ❑ Disturbs others, awake most of the night

Preference to sleep:

❑ Left side ❑ Right side ❑ Back ❑ Tummy

Comments ____

____

____

Bathing / Showering: (Please tick the appropriate box)

❑ Independent ❑ With assistance ❑ Dependent

Type of aids used:

❑ Hand shower ❑ Shower chair ❑ Transport commode ❑ Hand rail in bathroom

Comments ____

____

____

____

Toileting: (Please tick / circle)

Does she/he use toilet:

❑ Independently ❑ With assistance ❑ Dependent

Does she/he indicate need to use toilet Yes / No

Does she/he have toileting accidents Yes / No

Does she/he have incontinence Yes / No

❑ Bladder ❑ Bowel

Does she/he use continence aids Yes / No

Type: ____

Comments ____

____

____

____

Mobility: (Please tick)

❑ Independently mobile ❑ Needs assistance

❑ Uses frame or stick ❑ Uses wheelchair–electric/manual

Can she/he transfer from chair/to bed/to car Yes / No

Does the person have difficulty with:

❑ Stairs ❑ Uneven ground ❑ Slopes ❑ Standing alone for length of time

❑ Getting into and out of chairs

Comments ____

____

____

____

Transport:

Is she/he able to travel in: (Please circle)

Car	Yes / No	Bus	Yes / No
Taxi	Yes / No	Disabled Taxi	Yes / No

Behaviour: (Please circle)

When in the community does the person:

Stay with the carer	Yes / No	Wander off	Yes / No
Talk to strangers	Yes / No	Touch strangers	Yes / No
Become distressed	Yes / No		

Does the person exhibit any of the following behaviours? (Please circle)

Aggressive to others Yes / No

- ❑ Verbal
- ❑ Physical

Tantrums	Yes / No	Self injurious	Yes / No
Non compliant	Yes / No	Ritualistic behaviours	Yes / No
Fear/Phobia	Yes / No	Sexual behaviours	Yes / No
Eat non edible food	Yes / No		

Other behaviours (please give details) ____

____

____

____

What triggers this behaviour? ____

____

How do you manage the behaviour? ____

____

Is there a formal behavioural management plan, if so please attach copy to this assessment.

Recreation and Leisure

Favourite activities: ____

Interests: ____

Particular dislikes: ____

Prohibited activities: ____

Activities enjoyed: (Please circle any of the below activities enjoyed)

Shopping, video's, movies, music, walking, magazines, swimming, craft, painting, visiting places of interest, picnics, horse riding, reading, mini golf, football,

other ____

Do you receive respite care from any other service organisations? Yes / No

____

____

Do you consent to this information being made available to the Service Contractors used by the Far West Carer Respite Centre to provide support to the person in this assessment.

Yes / No

Signature: ____ Date _______________________

Print name: ____