Initial Comprehensive Assessment

Client Name *

The Client is the person receiving care

John Doe

Assessor Name *

Who is completing this form

Florence Nightingale

Acquisition Type *

Where an Initial Comprehensive Assessment (ICA) may not be required.

- (●) New Business - Comprehensive Data Collection
- ( ) New Business - Personal Care is required
- ( ) ICA Not Required

ICA Not Required

In some cases an Initital Comprehensive Assessment may not be required

Please detail why in this case an ICA is not required

Support Framework

Supports

	Informal	Other	Requires more support	None
Please Select	◉	○	○	○

Current Caregiver

	Spouse	Sibling	Offspring	Other
Please Select	○	○	◉	○

Caregiver Occupation

Caregiver Stress

	Not Evident	Low	Moderate	High	NA
Please Select	○	○	○	◉	○

Comments

Daughter Maria primary carer, evidence of carer burnout

Social Factors

Date of Birth

DD MM YYYY

/ /

Socially Engaged

	Frequently	Occasionally	Seldom	Never
Please Select	○	◉	○	○

Marital Status

	Married	Divorced	Widowed	Single
Please Select	○	○	◉	○

Comments

Wife passed away 2 months ago

Comments

Accommodation

	House	Apartment	Supported Living	Care Home	Other
Please Select	◉	○	○	○	○

Configuration

	One	Two	Three
Number of Levels	○	◉	○
Number of Flights of Stairs	◉	○	○

Lives *

- ◉ Alone
- ○ With Spouse
- ○ With Family
- ○ Other

Personal Care Delivery

The NDIS applies special conditions to the provision of Personal Care/Support where the person lives alone that can be broadly applied across all our prospects and clients. Answering the following questions in addition to your earlier responses allows us to identify the extent to which the client is living alone and their vulnerability, to ensure that we manage their care team accordingly.

While living alone they ... *

- [ ] have limited or no regular, face-to-face contact with relatives, friends or other people with whom the participant is well-acquainted
- [x] have limited or no physical mobility, without the assistance of another person,.
- [x] use equipment to enable them to be physically mobile or to facilitate their physical mobility.
- [ ] have limited or no ability to communicate with others without the assistance of another person, .
- [x] use equipment to enable or facilitate communication with others, including to enable or facilitate the use of a phone or other device.
- [ ] are not vulnuerable
- [ ] Other: .....

If you assess they are not vulnuerable, why ...

.....

Outstanding Care Related Issues

Issues

List any current issues along with the Required Actions and the Action By date - (one issue per line)

.....

Long Term Conditions

List any Long Term Conditions with its associated Management Plan - (one condition per line)

Rotator cuff weakness, lack of muscle
Hearing impairment
Neuropathy feet
Osteoarthritis
Hypertension
Cataracts

.....

General Background Observations

List any other observations germane to the care to be provided and important to the Care Plan

.....

Psychological Condition

Cognition

Note: If Dementia presents a Mental Capacity Assessment may be required

	Within Normal Limits	Mild Cognitive Impairment	Dementia	Other
Please Select	◉	○	○	○

Behaviour

	Presents as Normal	Wanders	Aggressive	Disoriented	Agitated	Withdrawn	Non Compliant
Please Select	☑	☐	☐	☐	☐	☑	☐

Behavioural Management Strategies

.....

Emotions

	Within Normal Range	Experiences Mood Swings	Signs of Depression	Is Anxious	Fatigue	Hallucinates	Delusional	Other
Please Select	☐	☐	☑	☐	☐	☐	☐	☐

Motivation

	1	2	3	4	5	
High	○	○	○	○	◉	Low

Health Attitude

	Excellent	Good	Fair	Poor	Couldn't say
Please Select	○	○	○	◉	○

Communication

	Within Normal Limits	Impaired
Speech	◉	○
Vision	○	◉
Hearing	○	◉
Understanding	◉	○

Communication aids

In the event of any impairment please indicate what aids are in use and what assistance is required - (use one line per aid)

Has glasses
Has hearing aids but doesn't wear them

Comments

Physiological Condition

ADLS
Activities of Daily Living or Physical Self-Maintenance

	Independent	Assisted	Dependent
Feeding	◉	○	○
Bathing	○	◉	○
Dressing	○	◉	○
Toilet	◉	○	○

Strength

	Within Normal Limits	Impaired
Please Select	○	◉

Exercise Regime

	Frequent	Occasional	Never
Please Select	○	◉	○

Balance

	Within Normal Limits	Impaired
Please Select	○	◉

Falls

	None	Only Recently	Occasionally	Frequently
Please Select	○	○	◉	○

Comments

.....

Physiological Condition - Mobility

Walking - Inside

	Independent	Slow	Assisted	Non-Weight bearing
Please Select	○	◉	○	○

Walking - Outside

	Independent	Slow	Assisted	Dependent
Please Select	○	○	◉	○

Transfers

	Independent	Standby	Assisted	Dependent
Please Select	○	○	◉	○

Bed (in/out)

	Independent	Assisted	Dependent
Please Select	○	◉	○

Aids Used

	None	Stick	Frame	Chair	Lifter
Please Select	☐	☐	☑	☐	☐

Comment

4ww for bad days
Assistance for transfers in and out of bed
Ok once up and on feet

Physiotherapy

	NA	In Place	Recommended
Select	○	○	◉

Occupational Therapy

	NA	In Place	Recommended
Select	◉	○	○

Comments

Physiological Condition - Nutrition & Eating

Body Mass

	Normal	Under	Over	Obese
Please Select	◉	○	○	○

Weight

In Kilograms

Height

In Centimetres

.....

Appetite

	Within Normal Limits	Fair	Poor	Excessive
Please Select	○	◉	○	○

Swallow

	Within Normal Limits	Impaired Fluids	Impaired Solids
Please Select	☑	☐	☐

Diet

.....

Dietitian

	NA	In Place	Recommended
Select	◉	○	○

Speech Therapy

	NA	In Place	Recommended
Select	◉	○	○

Comment

.....

Physiological Condition - Personal Care

Bathing

	Bath	Shower	Sponge
Select	☐	☑	☐

Frequency

	Daily	Every Other	Three Times per Week	Weekly
Select	○	◉	○	○

Time of Day

	Morning	Afternoon	Evening
Select	☑	☐	☐

Assistance

	Independent	Prompting	Supervision Required	Assistance
Select	○	○	○	◉

Bathing Aids

	Rails	Stool	Chair	Hygiene Sling	Other
Select	☐	☐	☑	☐	☐

Teeth

Condition of teeth

	Own	Partial - Dentures	Full - Dentures	Broken, painful
Upper	☑	☐	☐	☐
Lower	☑	☐	☐	☐

Dentist Name

.....

Last Visit Date

DD MM YYYY

__ / __ / ____

Frequency

	6 Months	12 Months	On Demand	Unknown
Select	☐	☐	☐	☑

Grooming

	Independent	Assistance	Hair Dresser/Barber	Shaving
Select	☐	☑	☐	☐

Dressing

	Independent	Assistance
Select	○	◉

Comments

Physiological Condition - Elimination

Bowel

	Continent	Incontinent	Constipated
Please Select	◉	○	○

Bladder

	Continent	Incontinent	Catheter
Please Select	○	◉	○

Aids

	Ostomy Bag	Cathether	Pads	N/A
Please Select	☐	☐	☑	☐

Assistance Required

	Yes	No
Please Select	☑	☐

Comments

Wears a slip pad overnight due to frequency

Physiological Condition - IADL

Instrumental Activities of Daily Living

Daily Living Activities

	Independent	Assisted	Dependent
Cooking	○	○	◉
Cleaning	○	○	◉
Shopping	○	○	◉
Medications	○	○	◉
Driving	○	○	◉
Banking	○	○	◉

Comments

Physiological Condition - Sleep

Sleep Pattern

	Disrupted	Daytime Drowsiness	Sleeps well
Please Select	○	○	◉

Routine

Preparation prior to going to bed

Wakefulness

	Pain	Toilet	Repositioning	Other
Please Select	☐	☑	☐	☐

Going to Bed Time

Time

__ : __

Getting Up Time

Time

__ : __

Comments

Medication and Related

Allergies

Please add a line for each of the Medications for which there is an allergic reaction and the reaction experienced

Penecillin

Smoking

	Never	Has Quit	Social	Heavy
Select	◉	○	○	○

Quit When

DD MM YYYY

__ / __ / ____

Comment

.....

Alcohol

	Never	Occasionally	Social	Heavy
Please Select	○	○	○	○

Medication

Asterisk* any medications that were started in hospital if applicable - Consider Stop / Start

List per line, the Medication Name, the Dosage , when it was commenced and if there is an end date.

.....

Administration

	Self	Dose Aid	Prompt	Assist
Select	☐	☑	☐	☐

Pharmacy

	Deliver	Pick Up
Select	○	◉

Frequency

	Weekly	Monthly	As Required
Select	○	○	◉

Sign Sheets

	Yes	No
Select	○	◉

Non Prescription Medication

Comments

Directives

Power of Attorney or Guardianship

	Has been signed	Yet to be formalised
Please Select	○	◉

Advanced Care Directive in place: *

	Yes	No
Please Select	○	◉

CPR Action *

	Allow a natural death	Resuscitate
Please Select	○	◉

Observations

Date Assessed *

DD MM YYYY

14 / 02 / 2022