

# Department of Adult Services

## Application for an occupational therapy assessment in activities of daily living / Disabled Facilities Grant



NHS number  (If Known)

Please complete the form using BLOCK CAPITALS. To help us avoid delays, please complete all sections in full. We will use the information you provide to decide whether or not you are eligible for an occupational therapy assessment. If you are unable to fill in this form, please contact us on **01942 828777**.

**Please refer to the guidelines enclosed when completing this form**

**Title** (please tick):  Mr.  Mrs.  Miss  Ms.

<b>Surname:</b>	<input type="text"/>	<b>First Name:</b>	<input type="text"/>
<b>Address:</b>	<input type="text"/>	<b>Postcode:</b>	<input type="text"/>
		<b>Date of birth:</b>	<input type="text"/>
<b>Home phone number:</b>	<input type="text"/>	<b>Work phone number:</b>	<input type="text"/>
<b>Marital Status:</b>	<input type="text"/>	<b>Do you live alone?</b>	
<b>Who do you live with?</b>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Who owns your home?** (please tick):

- Wigan Council
- A housing association
- You own it (owner occupied)
- Privately rented
- Other (please give details): \_\_\_\_\_

Is this your permanent address YES  NO

**What is your property type?** (please tick)

- House
- Bungalow
- Ground floor flat
- Upstairs flat
- Other (please give details): \_\_\_\_\_

**What are your medical problems or disabilities, and how long have you had them?**  
(Please include any memory or mental health problems):

**Box 1**

**Have you been admitted to hospital within the last 3 months?**

Yes     No

**Box 2**

Please advise when this happened

What caused you to be hospitalised?

**Have you received any form of rehabilitation within the last 12 months?**

Yes     No

**Box 3**

Where did this take place?

Was this rehabilitation as a result of:-  
Illness?

Yes     No

Injury?

Yes     No

Please give details

**What problems with day-to-day activities do you need help with?**

**Box 4**

**What do you think would resolve your difficulties?**

**Box 5**

### **Important:**

**We need a response to all these questions in order to make an accurate assessment.**

Please tick the box which is most applicable to your situation. It is important that you answer all questions.

### **Mobility**

**Can you stand unaided?**

Yes     No

**Do you use a walking aid?**

No     Walking Stick     Walking Frame  
 Other \_\_\_\_\_

**Do you use a wheelchair?**

Yes     No

**If yes, please tick description**

Self propell     Attendant     Electric

**Do you use your wheelchair?**

Indoor     Outdoor     Both

**Is there anything else you think we should know about your mobility?**

	I Can do this myself	I Can do This myself with equipment	I need help from someone to do this	I am not able to do this
<b>Personal Care</b>				
Can you dress/undress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you comb your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you strip wash?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you get in/out of your bath or shower?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What bathing facilities do you have?

Bath	Overbath shower	Shower cubicle	Level Access Shower	Bath hoist
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Is there anything else you think we should know about your bathing?**

	I Can do this myself	I Can do This myself with equipment	I need help from someone to do this	I am not able to do this
<b>Transfers</b>				
Can you get on/off your toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you get on/off your chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you get on/off your bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you get in/out of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you get on/off a bus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Is there anything else you think we should know about your transfers?**

Please use this space to tell us about any difficulties you have with transfers and to describe how you currently transfer.

	I Can do this myself	I can do this myself but struggle	I can do this with the help of someone	I am not able to do this
<b>Access</b>				
Can you get in/out of the house?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any difficulties getting to the main rooms in your house?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Is there anything else you think we should know about your access?**

	I Can do this myself	I can do this myself but struggle	I can do this with the help of someone	I am not able to do this
<b>Stairs (if applicable)</b>				
Can you manage your stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Do you have one stair rail or two?**  None  One  Two

**Describe your staircase?**  Curved  Straight

**Do you have a stairlift?**  Yes  No

**Do you have a through floor lift?**  Yes  No

**Is there anything else you think we should know about your stairs?**

	I Can do this myself	I Can do This myself with equipment	I need help from someone to do this	I am not able to do this
<b>Domestic care</b>				
Can you feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you get yourself a drink?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you get yourself a snack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you get yourself a meal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you do your laundry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you do your housework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you manage your finances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Is there anything else you think we should know about your domestic care?**

**What equipment do you have?**

**Have you had any falls within the last year?**

Yes

No

If **yes**, please tell us how many, where they happened and what caused them?

Number of falls ....

Do you have speech difficulties?  Yes  No

Are you blind or partially sighted?  Yes  No

Are you deaf or hard of hearing?  Yes  No

Do you receive help from any of the services below (please tick):

- Home care
- Community meals delivered
- Social worker
- Occupational therapist (OT)
- District nurse
- Physiotherapist
- Day centre
- Falls clinic
- Enablement services

Do you receive any other help from Wigan Council's Department of Adult Services?

Do you have help from a carer?  Yes  No  
(e.g. your husband or wife, relative, friend, other)

If **yes**, say who?

How often do they care for you?

What are the main problems your carer experiences in caring for you?

If **yes**, say who?

How often do they care for you?

What are the main problems your carer experiences in caring for you?

Is there anything else you think we should know about your situation?

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Please give details of times you are routinely UNAVAILABLE so that we can plan our visits around them:

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**Next of Kin**

<b>Surname:</b>		<b>First Name:</b>	
<b>Address:</b>		<b>Postcode:</b>	
		<b>Telephone Number</b>	

Would you prefer us to discuss your application with a family member/friend rather than yourself?  Yes  No

Is this person your next of kin?  Yes  No

If no please give their details here

<b>Surname:</b>		<b>First Name:</b>	
<b>Address:</b>		<b>Postcode:</b>	
		<b>Telephone Number</b>	

**Your consent to contact your doctor or consultant:**

It may be necessary for us to contact your doctor or consultant if you have one to clarify medical information. Please provide all details below:

**Your doctor's/  
consultants name:** \_\_\_\_\_

**Their address:** \_\_\_\_\_

**Their phone number:** \_\_\_\_\_

**Your consent:**

I agree to you contacting my doctor / consultant to clarify medical information:

**Your signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Declaration:**

I confirm that the information I have provided in this form is true and correct:

**Your signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

If you have completed this form on behalf of the applicant, please sign and date the section below:

**Signature:** \_\_\_\_\_

**Relationship to applicant:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_

**Reason applicant could not complete the form:**  
\_\_\_\_\_

## Equal opportunities monitoring:

We shall be grateful if you will complete the information below. This is to help us to make sure we are meeting the whole community's needs.

**What is your ethnicity?** Please tick the most appropriate box:

### White

- British
- Irish
- Traveller of Irish Heritage
- Gypsy / Roma
- Other (please state) \_\_\_\_\_

### Black or Black British

- Caribbean
- African
- Other (please state) \_\_\_\_\_

### Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Other (please state) \_\_\_\_\_

### Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Other please state) \_\_\_\_\_

### Chinese or other ethnic group

- Chinese
- Other (please state) \_\_\_\_\_

### Refuse to give information

- Worker or referrer refuses to say
- Applicant refuses to say

**Thank you for completing this form.** Please return it to: Central Duty Team, Wigan Council, Department of Adult Services, Hyndelle Lodge, King Street, Hindley, Wigan, WN2 3AW

## For office use only:

Eligible for assessment

Yes  No

Reason for decision by Duty Officer

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Service user informed

Yes  No

Comments/ further actions

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Duty

Signature:

Date

Manager's Decision

FACS Assessment type

- Low  
 Moderate  
 Substantial  
 Critical

Outcome of duty assessment

- Prevention – redirected to other services  
 Prevention - eligible needs/duty issue  
 Enablement  
 Long term conditions management/Palliative care

Waiting list

- Enablement team  
 OT Waiting List  
 SDO Waiting List  
 DO Waiting List

Allocated worker: \_\_\_\_\_

Date: \_\_\_\_\_

Manager \_\_\_\_\_

Date: \_\_\_\_\_

Admin

<input type="checkbox"/>	Date Letter sent to confirm
<input type="checkbox"/>	FACS Leaflet
<input type="checkbox"/>	OT Directory of Contacts/Prevention
<input type="checkbox"/>	Comments Form



## Application for an occupational therapy assessment in activities of daily living

# A guide to completing the form

Please complete the form as fully as you can. We will use the information you give us to assess your eligibility for services and to determine the most appropriate response to your application.

**Page 1** - Information about you and where you live. Please include your NHS number if this is known. Your NHS number is printed on your medical card given to you when you register with a GP practice.

### Page 2:

- **Box 1**  
Please tell us about your medical problems or disabilities, including how long you have had them. Tell us about your symptoms include details of any pain you suffer. Please include any memory or mental health problems.
- **Box 2**  
Please tell us about any recent admission to hospital, please give approximate dates, and the reason you were in hospital.
- **Box 3**  
Please tell us if you have received any rehabilitation in the last 12 months. Please tell us if this was with an Occupational Therapist, a Physiotherapist or Speech and Language Therapist. Please tell us where it took place for example; in your own home, in hospital, in a clinic or day centre.

### Page 3

- **Box4**  
Please tell us how your disabilities affect day to day activities and the type of things you need help with. For example, difficulty walking and unable to climb the stairs to access the toilet.
- **Box 5**  
Please tell us what type of equipment or adaptation you feel could assist you with the difficulties you are having. For example a second stair rail, or a frame for the toilet. If you don't know, please say you don't know.
- **Mobility**  
Please put a tick in each of the boxes that apply to you. Use the text box at the top of page 3 to tell us anything else we need to know about your mobility. For example if you have poor balance or can only walk a short distance, include details of how far you can walk if this is restricted.

### Page 4:

- **Personal Care**  
Please complete the tick boxes. Use the text box to tell us anything else we need to know about your personal care. For example if you have home care or family to assist you, or you have other bathing equipment.

- **Transfers (how you get on and off things)**  
Please complete the tick boxes. Use the text box to tell us anything else we need to know about your transfers. For example any equipment you have to assist with transfers such as a frame around the toilet or a hoist. If home care or family assist you and the extent to which they struggle to assist. If difficult please describe the method you currently use to transfer. For example if it takes a number of attempts to get up from your chair, or you pull yourself up from the toilet using a radiator or grab rail. Include any pain you feel during transfers.

-2-

**Page 5:**

- **Access**  
Please complete the tick boxes. Use the text box to tell us anything else we need to know about access to the property or getting into the main rooms of the house. For example if you have grab rails at the front door or you use a wheelchair inside the property and the doorways are too narrow for you to get through.
- **Stairs**  
Please complete the tick boxes. Use the text box to tell us anything else we need to know about use of stairs. For example you have a stairlift but can no longer get on/off safely. Your carer physically assists you on the stairs but they are frail. If you get very short of breath or using the stairs is painful.

**Page 6**

- **Domestic care**  
Please complete the tick boxes. Use the text box to tell us anything else we need to know about your domestic care. For example, your carer / spouse / family do all domestic chores.
- **What equipment do you have?**  
Please tell us of any specialist equipment you have to assist with your disability. For example, a hoist, a bed lever or chair raisers.
- **Falls**  
Please tell us about any falls you have had in the past year include the number of falls and details of where they happened and what was the cause. For example if you tripped over a rug, or your legs gave way.

**Page 7:**

- **Sensory (first three questions)**  
please complete the tick boxes.
- **Help from Wigan Council Adult Services**  
Please complete the tick boxes. Use the text box to tell us about any other help you receive from Wigan Council's Department of Adult Services. For example, telephone care line (Elder care).
- **Help from a carer**  
Please tell us about any help you have from informal carers such as you husband, wife, or family. Tell us if your carer has difficulty in providing care for example if they are frail or ill themselves.

**Page 8:**

- **Additional Information**

Please use the text box to tell us any other information that you feel we should know about your situation when we are assessing your eligibility for services from the council's Occupational Therapy team. Please continue on a separate sheet if necessary.

- **Availability**

Please tell us when you are routinely unavailable, for example if you have a regular appointment or receive day services on a particular day.

- **Next of Kin**

Please give details of your next of kin.

- **Contacts**

If you prefer us to discuss your application with another person rather than with yourself please indicate this. If this person is not your next of kin please give details so we can contact them on your behalf. Leave blank if you want us to contact you direct.

**Page 9**

- **Your consent**

If you are seeing a consultant about your disability or illness please give their details. If not please give your Doctors details.

**Page 10**

- **Declaration**

Please complete

**Page 11**

- **Equal opportunities monitoring**

Please complete

- **Return address**

Please return to form to this address in the free post envelope provided or, if you have downloaded this form, to: Central Duty Team, Wigan Council, Hyndelle Lodge, King Street, Hindley, Wigan, WN2 3AW.

Thank you for completing the form.

When we receive it, a member of the council's Central Duty Team will contact you to confirm it has been received. It will then be passed to the Occupational Therapy Team who will write to you to let you know the outcome of your application. If the outcome is that you are not eligible to receive services from the occupational therapy team, we will provide you with details of other services that may be able to help.