

# Activities of Daily Living

## About this domain – ADLs

To identify the need for support in completing basic daily activities including eating, bathing, dressing, personal hygiene/grooming, toileting, mobility, positioning and transfers.

### Information gathered includes:

- Level of need for oversight/cuing/supervision and physical assistance
- Challenges and strengths
- Need for training
- Equipment needs

## Eating

**Does the person have any difficulties with eating or require support or assistance with eating?** *(If 'Yes' or 'Sometimes' is selected, the following questions will be displayed)*

- No
- Yes
- Sometimes
- Chose not to answer

### Cuing and Supervision

- None
- To initiate the task
- Intermittently during the task
- Constantly throughout the task

### Physical Assistance

- None
- Setup/Prep
- Limited
- Extensive/Total Dependence

**Does the physical assistance constitute 'significantly' increased direct hands-on assistance and interventions?** *(Displays only if Extensive/Total Dependence is checked above)*

- No
- Yes

**In regard to the ability to manage eating by themselves, this person** *(Displays only if age is 18 or older):*

- Can eat without help of any kind
- Needs and gets minimal reminding or supervision
- Needs and gets help in cutting food, buttering food or arranging food
- Needs and gets some personal help with feeding or someone needs to be sure that you don't choke
- Needs to be fed completely or tube feeding or IV feeding

**In regard to the ability to manage eating, this child** *(Displays only if age is 17 or older):*

- Independent
- Intermittent supervision or reminders
- Needs constant supervision and/or assistance in setting up meals, i.e. cutting meat, pouring fluids
- Needs physical assistance. Child can partially feed self. (N/A 0-24 months)
- Needs and receives total oral feeding from another. Child is physically unable to participate. (N/A 0-12 months)
- Receives tube feeding. Child has documented incidents of choking or reflux on a weekly basis or more that is related to diagnosis or disability.

**Strengths - What does the person do well while eating?**

- Behavioral issues
- Cannot cut food
- Chewing problem
- Choking problem
- Disease/symptoms interfere with performing task
- Mouth pain
- Poor appetite
- Poor hand to mouth coordination
- Problems with taste
- Swallowing problem
- Other:
- Other:

Comments:

### Strengths - What does the person do well while eating?

- Cooperates with caregivers
- Has a good appetite
- Independent with equipment/adaptations
- Manages own tube feeding
- No swallowing problems
- Person is motivated
- Takes occasional food by mouth
- Other:
- Other:

Comments:

### Preferences - What does the person prefer when eating?

- Bland diet
- Cold food
- Eat alone
- Eat with others present
- Finger foods
- Hot food
- Large portions
- Small portions
- Snacks
- Use own recipes
- Other
- Other

Comments:

### Support Instructions - What helps the most when assisting the person with eating?

- Able to manage their own need
- Cut food into small pieces
- Follow complex feeding protocol
- Hand-over-hand assistance
- Monitor liquids
- Monitor for choking
- Plate to mouth
- Provide cues
- Scalding alert
- Tube feeding
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

Comments: \_\_\_\_\_

### Is training/skill building needed to increase independence?

- No
- Yes

Comments: \_\_\_\_\_

Notes/ Comments: \_\_\_\_\_

### Eating ADL has been assessed? *(Displays for reassessment only)*

- Yes



## Eating Equipment

Does the person need any adaptive equipment to assist with eating?

- No
- Yes
- Chose not to answer

Comments: \_\_\_\_\_

*If Yes is selected, the 'Eating Equipment Status' table will be displayed:*

**Eating Equipment Status (Select all that apply):**

Type	Has and Uses	Has and does not use	Needs	Comments
Adapted cup	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Adapted utensils	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Dentures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Dycem mat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Gastrostomy tube	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Hickman catheter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
IV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Jejunostomy tube	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Nasogastric tube	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Plate guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Specialized medical equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Straw	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

Notes/Comments: \_\_\_\_\_

## Bathing

**Do you have any difficulties with bathing or require support or assistance during bathing?**

- No
- Yes
- Sometimes
- Chose not to answer

Comments: \_\_\_\_\_

***If 'Yes' or 'Sometimes' was selected, the following questions will be displayed:***

### **Cuing and Supervision**

- None
- To initiate the task
- Intermittently during the task
- Constantly throughout the task

### **Physical Assistance**

- None
- Setup/Prep
- Limited
- Extensive/Total Dependence

**Does the physical assistance constitute 'significantly' increased direct hands-on assistance and interventions? (*Displays only if Extensive/Total Dependence is checked above*)**

- No
- Yes

**In regard to the ability to bathe or shower, this person (*Displays only if Age >= 18*)**

- can bathe or shower without any help
- needs and gets minimal supervision or reminding
- needs and gets supervision only
- needs and gets help getting in and out of the tub
- needs and gets help washing and drying their body
- cannot bathe or shower, needs complete help

**In regard to the ability to bathe, this child** *(Displays only if Age <= 17)*

- Independent
- Intermittent supervision or reminders
- Needs help in and out of tub
- Constant supervision, but child does not need physical assistance
- Physical assistance of another, but child is physically able to participate
- Totally dependent on another for all bathing. Child is physically unable to participate

**Challenges – What difficulties does the person have with bathing?**

- Behavioral issues
- Afraid of bathing
- Cannot be left unattended
- Cannot judge water temperature
- Disease/symptoms interfere with performing task
- Unable to shampoo hair
- Unable to stand alone
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Comments: \_\_\_\_\_

**Strengths – What does the person do well while bathing?**

- Able to direct caregiver
- Bathes self with cueing
- Cooperates with caregiver
- Enjoys bathing
- Person is weight bearing
- Safe when unattended
- Shampoos hair
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Comments: \_\_\_\_\_



**Preferences – What does the person prefer when bathing?**

- Bath
- Bed bath
- Female caregiver
- Male caregiver
- Shower
- Sponge bath
- Use specific products
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Comments: \_\_\_\_\_

**Support Instructions – What helps the most when assisting the person with bathing?**

- Able to manage their own need
- Assist with drying and dressing
- Cue throughout bath
- Cue to bathe
- Give bed/sponge bath
- Shampoo hair
- Soak feet
- Standby during bathing
- Transfer in/out of tub/shower
- Wash back, legs, feet
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Comments: \_\_\_\_\_

**Is training needed to increase independence?**

- No
- Yes

Comments: \_\_\_\_\_

**Notes/Comments:** \_\_\_\_\_

**Bathing ADL has been assessed?**

- Yes



## Bathing Equipment

Does the person need any adaptive equipment to assist with bathing?

- No
- Yes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' was selected, the following 'Bathing Equipment Status' table will be displayed:*

**Bathing Equipment Status (Select all that apply):**

Type	Has and Uses	Has and does not use	Needs	Comments/Supplier
Bath bench	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Grab bars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Hand-held shower	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Hoyer Lift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Roll-in shower chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Shower chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Specialized medical equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Transfer bench	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

Notes/Comments: \_\_\_\_\_

### Dressing

**Does the person have any difficulties with dressing or require support or assistance during dressing?**

- No
- Yes
- Sometimes
- Chose not to answer

Comments:

*If 'Yes' or 'Sometimes' was selected, the following questions will be displayed:*

### Cuing and Supervision

- None
- To initiate the task
- Intermittently during the task
- Constantly throughout the task

### Physical Assistance

- None
- Setup/Prep
- Limited
- Extensive/Total Dependence

**Does the physical assistance constitute 'significantly' increased direct hands-on assistance and interventions?**

*(Displays only if Extensive/Total Dependence is checked above)*

- No
- Yes

**In regard to the ability to manage dressing, this person** *(Displays only if Age >= 18)*

- can dress without any help
- needs and gets minimal supervision
- needs some help from another person to put clothes on
- cannot dress themselves, somebody else dresses them
- is never dressed

**In regard to the ability to manage dressing, this child** *(Displays only if Age <= 17)*

- Independent
- Intermittent supervision or reminders. may need physical assistance with fasteners, shoes or laying out clothes
- Constant supervision, but no physical assistance (N/A 0-48 months)
- Physical assistance or presence of another at all times, but child is able to physically participate (N/A 0-36 months)
- Totally dependent on another for all dressing. Child is unable to physically participate (N/A 0-12 months)

**Challenges – What difficulties does the person have with dressing?**

- Behavioral issues
- Cannot button clothing
- Cannot dress lower extremities
- Cannot lift arms
- Cannot put on shoes/socks
- Disease/symptoms interfere with performing task
- Unable to tie
- Unable to undress independently
- Unable to zip
- Will wear dirty clothes
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Strengths – What does the person do well when dressing?

- Able to direct caregiver
- Buttons clothing
- Cooperates with caregiver
- Gets dressed with cueing
- Person is motivated
- Puts on shoes and socks
- Uses assistive device
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Preferences – What does the person prefer when dressing?

- Changes clothes multiple times daily
- Choose own clothes
- Female caregiver
- Male caregiver
- Same clothing daily
- Velcro closures
- Wears loose clothing
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Support Instructions – What helps the most when assisting the person with dressing?

- Manage their own need
- Dress person's lower body
- Help select clean and/or matching clothes
- Dress person's upper body
- Put on/take off footwear
- Label/organize clothing by color, style, etc.
- Put on/take off sock/TED hose
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_



**Is training needed to increase independence?**

- No
- Yes

Comments: \_\_\_\_\_

**Notes/Comments:**

\_\_\_\_\_

**Dressing ADL has been assessed?** *(Displays for reassessment only)*

Yes



## Dressing Equipment

Does the person need any adaptive equipment to assist with dressing?

- No
- Yes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' was selected, the 'Dressing Equipment Status' table will be displayed:*

**Dressing Equipment Status** *(Select All that Apply):*

Type	Has and Uses	Has and does not use	Needs	Comments/Supplier
Adapted clothing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Button hook	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Elastic shoe laces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Helmet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Orthotics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Prosthesis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Protective gear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Reacher	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Sock aid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Specialized medical equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
TED hose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

**Notes/Comments:** \_\_\_\_\_

## Personal Hygiene/Grooming

**Does the person have any difficulties with or require support or assistance to take care of their grooming and hygiene needs?**

- No
- Yes
- Sometimes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' or 'Sometimes' was selected, the following questions will be displayed:*

### Cuing and Supervision

- None
- To initiate the task
- Intermittently during the task
- Constantly throughout the task

### Physical Assistance

- None
- Setup/Prep
- Limited
- Extensive/Total Dependence

**Does the physical assistance constitute 'significantly' increased direct hands-on assistance and interventions?**

*(Displays only if Extensive/Total Dependence is checked above)*

- No
- Yes

**In regard to the ability to manage grooming activities, this person**

*(Displays only if Age >= 18)*

- can comb hair, wash face, shave or brush teeth without help of any kind
- needs and gets supervision or reminding about grooming activities
- needs and gets daily help from another person
- is completely groomed by somebody else

### In regard to the ability to manage grooming activities, this child

*(Displays only if Age <= 17)*

- Independent
- Intermittent supervision or reminders.
- Help of another to complete the task, but child is able to physically participate (N/A 0-48 months)
- Totally dependent on another for all dressing.
- Child is unable to physically participate (N/A 0-24 months)

### Challenges – What difficulties does the person have taking care of their own grooming/hygiene needs?

- Behavioral issues
- Cannot brush/comb hair
- Cannot brush teeth
- Cannot do own peri care
- Cannot raise arms
- Disease/symptoms interfere with performing task
- Unaware of grooming needs
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Strengths – What does the person do well in taking care of their own grooming/hygiene needs?

- Able to apply make-up, lotions, etc.
- Able to brush/comb hair
- Able to do own peri-care
- Able to trim nails
- Able to wash hands/face
- Aware of need to use toilet
- Brushes teeth/dentures
- Can shave themselves
- Cooperates with caregiver
- Person is motivated
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Preferences – What does the person prefer when taking care of their own grooming/hygiene needs?

- Assistance after eating
- Assistance before bedtime
- Disposable razor
- Electric razor
- Hair done in salon
- Prefers a female caregiver
- Prefers a male caregiver
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Support Instructions – What helps the most when assisting the person with their grooming/hygiene needs?

- Manage their own need
- Apply deodorant
- Assist to clean dentures
- Assist with menses care
- Comb hair as needed
- Cue to brush teeth
- Cue to comb hair
- Cue to wash face/hands
- Shave person daily or as needed
- Trim fingernails as needed
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Is training needed to increase independence?

- No
- Yes

Comments: \_\_\_\_\_

Notes/Comments: \_\_\_\_\_

### Personal hygiene/grooming ADL has been assessed? *(Displays for reassessment only)*

- Yes



## Personal Hygiene/Grooming Equipment

Does the person need any adaptive equipment to assist with grooming and hygiene tasks?

- No
- Yes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' was selected, the 'Personal Hygiene/Grooming Equipment' table will be displayed:*

### Personal Hygiene/Grooming Equipment *(Select All that Apply)*

Type	Has and Uses	Has and does not use	Needs	Comments/Supplier
Adapted toothbrush	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Dental floss holder/flossing aid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Dentures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Electric razor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Special type of toothbrush	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Splint	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

**Notes/Comments:**

\_\_\_\_\_

## Toilet Use/Continence Support

**Does the person need assistance or support with toileting?**

**Note to assessor: Self-managed incontinence does not constitute needing assistance or help with toileting.**

- No
- Yes
- Sometimes
- Chose not to answer

Comments:

*If 'Yes' or 'Sometimes' was selected, the following questions will be displayed:*

### Cuing and Supervision

- None
- To initiate the task
- Intermittently during the task
- Constantly throughout the task

### Physical Assistance

- None
- Setup/Prep
- Limited
- Extensive/Total Dependence

**Does the physical assistance constitute 'significantly' increased direct hands-on assistance and interventions? (*Displays only if Extensive/Total Dependence is checked above*)**

- No
- Yes

**In regard to the ability to manage using the toilet, this person** *(Displays only if Age >= 18)*

- can use the toilet without help, including adjusting clothing
- needs some help to get to and on the toilet, but doesn't have accidents
- has accidents sometimes, but not more than once a week
- only has accidents at night
- has accidents more than once a week
- has bowel movements in their clothes more than once a week
- wets their pants and has bowel movements in their clothes very often

**In regard to the ability to manage using the toilet, this child** *(Displays only if Age <= 17)*

- Independent
- Intermittent supervision, cuing or minor physical assistance such as clothes adjustments or hygiene. No incontinence. (N/A 0-60 months)
- Usually continent of bowel or bladder, but has occasional accidents requiring physical assistance (N/A 0-60 months)
- Usually continent of bowel or bladder, but needs physical assistance or constant supervision for all parts of the task. (N/A 0-60 months)
- Incontinent of bowel or bladder. Diapered. (N/A 0-48 months)
- Needs assistance with bowel and bladder programs, or appliances (i.e. ostomies or urinary catheters)

**Challenges – What difficulties does the person have with toileting and staying dry and clean?**

- Behavioral issues
- Cannot always find bathroom
- Cannot change incontinence pads Cannot do own peri care
- Cannot empty ostomy/catheter bag
- Experiences urgency
- Painful urination
- Refuses to use pads/briefs
- Requires peri-care after toilet use
- Unaware of need
- Wets/soils bed/furniture
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_



### Strengths – What does the person do well with toileting and staying dry and clean?

- Able to use incontinence products
- Assists caregiver with transfer
- Aware of need to use toilet
- Can toilet with cueing
- Cooperates with caregiver
- Does not need assistance at night
- Empties own ostomy/catheter bag
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Preferences – What does the person prefer when being supported to stay dry and clean?

- Bed pan only
- Bedside commode
- Female caregiver
- Male caregiver
- Pads/briefs when going out
- Specific products
- Urinal
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

**Support Instructions – What helps the most when assisting the person with toileting?**

- Manage their own need
- Bowel/bladder program
- Change/empty catheter/ostomy bags
- Change pads as needed
- Clean catheter bag
- Cue to toilet
- Provide or cue to do peri-care
- Toilet person regularly
- Transfer person on/off toilet
- Use condom catheter as needed
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

**Is training needed to increase independence?**

- No
- Yes

Comments: \_\_\_\_\_

**Notes/Comments:** \_\_\_\_\_

**Toileting ADL has been assessed?** *(Displays for reassessment only)*

- Yes



## Toilet Use/Continenence Support Equipment

Does the person need any adaptive equipment to assist with toileting or staying dry and clean?

- No
- Yes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' was selected, the 'Hygiene Equipment Status' table will display:*

### Hygiene Equipment Status *(Select All that Apply):*

Type	Has and Uses	Has and does not use	Needs	Comments/Supplier
Barrier cream	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Bed pad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Bed pan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Incontinence briefs/pads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Colostomy bag	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Commode	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Disinfectant spray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
External catheter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Gloves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Grab bars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Ileostomy bag	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Internal catheter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Mattress cover	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Raised toilet seat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Specialized medical equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Urinal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

Notes/Comments: \_\_\_\_\_

## Mobility – Walking and Wheeling

**Does the person have any difficulty with mobility or require support or assistance to get around?**

- No
- Yes
- Sometimes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' or 'Sometimes' was selected, the following questions will be displayed:*

### Cuing and Supervision

- None
- To initiate the task
- Intermittently during the task
- Constantly throughout the task

### Physical Assistance

- None
- Setup/Prep
- Limited
- Extensive/Total Dependence

**Does the physical assistance constitute 'significantly' increased direct hands-on assistance and interventions?** *(Displays only if Extensive/Total Dependence is selected above)*

- No
- Yes

**In regard to the ability to walk around, this person** *(Displays only if Age >= 18)*

- walks without help of any kind
- can walk with help of a cane, walker, crutch or push wheelchair
- needs and gets help from one person to help walk
- needs and gets help from two people to help walk
- cannot walk at all

### In regard to the ability to walk around, this child *(Displays only if Age <= 17)*

- Independent. Ambulatory without device.
- Can mobilize with the assist of a device, but does not need personal assistance
- Intermittent physical assistance of another (N/A 0-24 months) (This does not include supervision for safety of a child under age)
- Needs constant physical assistance of another. Includes child who remains bedfast. (N/A 0-12 months)

### Challenges – What difficulties does the person have getting around their home?

- Behavioral issues
- Activity limited; afraid of falling
- Cannot propel wheelchair
- Disease/symptoms interfere with performing task
- Leans to one side
- Misplaces/forgets assistive device
- Poor navigation
- Unable to exit in emergency
- Unable to walk/bear weight
- Will not use assistive device
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Challenges – What difficulties does the person have getting around their community?

- Behavioral issues
- Activity limited; afraid of falling
- Cannot open doors
- Difficulty navigating unfamiliar environments
- Disease/symptoms interfere with performing task
- Gets lost outside residence
- Needs assistance with stairs
- Needs assistance to evacuate
- Needs wheelchair for distance
- Poor safety awareness
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Strengths – What does the person do well?

- Able to exit in emergency
- Aware of own safety
- Cooperates with caregiver
- Has a steady gait
- Motivated
- Propels own wheelchair
- Sees well enough to navigate independently
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Strengths – What does the person do well when getting around their community?

- Can evacuate in emergency
- Has good endurance
- Independent with stairs
- Navigates safely in community
- Remembers to use assistive device
- Residence has ramp
- Will ask for assistance
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

Comments: \_\_\_\_\_

### Preferences – What does the person prefer when needing to get around their home?

- Can walk, but prefers wheelchair
- Cane
- Contact guard when walking
- Crutch
- Electric wheelchair
- Gait belt
- Manual wheelchair
- Pushed in wheelchair
- Walker
- Walker with seat
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

Comments: \_\_\_\_\_



### Preferences – What does the person prefer to get around their community?

- Contact guard
- Outings in the afternoon
- Outings in the morning
- Wheelchair
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

Comments: \_\_\_\_\_

### Support Instructions (In the Home) – What helps the most when assisting the person to get around their home?

- Manage their own need
- Always use a gait belt
- Assist person over thresholds
- Evacuation plan: call neighbor
- Evacuation plan: caregiver assistance
- Evacuation plan: use PERS
- Leave assistive device within reach
- Provide contact guard when walking
- Provide physical support with stairs
- Remind to use assistive device
- Recharge batteries daily
- Keep walkways clear
- Use gait belt
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

Comments: \_\_\_\_\_



### Support Instructions (In the Community) – What helps the most when assisting the person to get around the Community?

- Manage their own need
- Assist on uneven surfaces
- Cue to use evacuate
- Cue to use assistive device
- Keep assistive device within reach
- Res. Evacuation Level 1
- Res. Evacuation Level 2
- Res. Evacuation Level 3
- Set brakes for person
- Use gait belt
- Cue to evacuate
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Is training/skill building needed to increase independence?

- No
- Yes

Comments: \_\_\_\_\_

Notes/Comments: \_\_\_\_\_

### Mobility – Walking and Wheeling ADL has been assessed?

*(Displays for reassessment only)*

- Yes



## Mobility – Walking and Wheeling Equipment

Does the person have or need any adaptive equipment to assist with mobility?

- No
- Yes
- Sometimes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' was selected, the 'Mobility Equipment Status' table will be displayed:*

### Mobility Equipment Status *(select all that apply):*

Type	Has and Uses	Has and does not use	Needs	Comments/Supplier
Air pad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cane	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Crutch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Gait belt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Gel pad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Manual wheelchair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Motorized wheelchair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Medical response alert	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Medical response alert unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Prostheses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Quad cane	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Ramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Repositioning wheelchair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Room monitor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Scooter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Service animal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Specialized medical equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Splint/Braces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Walker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Walker with seat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

Notes/Comments: \_\_\_\_\_

## Positioning

**Does the person have any difficulties with positioning or require support or assistance when positioning?**

- No
- Yes
- Sometimes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' or 'Sometimes' was selected, the following questions will be displayed:*

### Cuing and Supervision

- None
- To initiate the task
- Intermittently during the task
- Constantly throughout the task

### Physical Assistance

- None
- Setup/Prep
- Limited
- Extensive/Total Dependence

*(Displays only if Extensive/Total Dependence is checked above)*

**\*Does the physical assistance constitute 'significantly' increased direct hands-on assistance and interventions?**

- No
- Yes

**In regard to the ability to manage sitting up or moving around, this person**

*(Displays only if Age >= 18)*

- Can move in bed without any help
- Needs and gets help sometimes to sit up
- Always needs and gets help to sit up at least daily
- Always needs and gets help to be turned or change positions

**In regard to the ability to manage turning and positioning, this child** *(Displays only if*

*Age <= 17)*

- Independent. Ambulatory without device.
- Needs occasional assistance of another person or device to change position less than daily.
- Needs intermittent assistance of another on a daily basis to change position. Child is physically able to participate.
- Needs total assistance in turning and positioning. Child is unable to participate.

**Challenges – What difficulties does the person have with positioning?**

- Behavioral issues
- Bedridden all/most of the time
- Cannot elevate legs/feet
- Disease/symptoms interfere with performing task
- Chair fast all/most of the time
- Falls out of bed
- Slides down in chair
- Slips down in bed
- Unable to use trapeze
- Unaware of need to reposition
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_



**Strengths – What does the person do well when repositioning?**

- Able to elevate legs
- Asks for assistance
- Aware of need to reposition
- Cooperates with caregiver
- Directs caregiver to assist with task
- Motivated
- Uses trapeze
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

**Preferences – What does the person prefer to be positioned?**

- Can walk, but prefers wheelchair
- Cane
- Contact guard when walking
- Crutch
- Electric wheelchair
- Gait belt
- Manual wheelchair
- Pushed in wheelchair
- Walker
- Walker with seat
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

**Support Instructions – What helps the most when assisting the person with repositioning?**

- Manage their own need
- Assist person to roll over
- Assist person to sit up in bed/chair
- Monitor pressure points daily
- Reposition at person's request
- Reposition as needed
- Use pillows/towels for support
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

**Is training/skill building needed to increase independence?**

- No
- Yes

Comments: \_\_\_\_\_

**Notes/Comments:** \_\_\_\_\_

**Positioning ADL has been assessed?** *(Displays for reassessment only)*

- Yes



## Positioning Equipment

Does the person have or need any adaptive equipment to assist with positioning?

- No
- Yes
- Chose not to answer

**Comments:**

*If 'Yes' was selected, the following questions will be displayed:*

**Positioning Equipment Status (select all that apply):**

Type	Has and Uses	Has and does not use	Needs	Comments/Supplier
Alternating pressure mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Bubble mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Brace	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Electronic bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Flotation mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Manual bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Posey or other enclosed bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Side rails	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Specialized medical equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Water mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

**Notes/Comments:** \_\_\_\_\_

## Transfers

**Does the person have any difficulties with transfers or require support or assistance when making transfers?**

- No
- Yes
- Sometimes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' or 'Sometimes' was selected, the following questions will be displayed:*

### Cuing and Supervision

- None
- To initiate the task
- Intermittently during the task
- Constantly throughout the task

### Physical Assistance

- None
- Setup/Prep
- Limited
- Extensive/Total Dependence

**Does the physical assistance constitute 'significantly' increased direct hands-on assistance and interventions?** *(Displays only if Extensive/Total Dependence is checked above)*

- No
- Yes

**In regard to the ability to get in and out of bed or a chair, this person**

*(Displays only if Age >= 18)*

- can get in and out of a bed or chair without help of any kind
- needs somebody to be there to guide them but they can move in and out of a bed or chair
- needs one other person to help
- needs two other people or a mechanical aid to help
- never gets out of a bed or chair

**In regard to the ability to manage transfers, this child** *(Displays only if Age <= 17)*

- Independent.
- Needs intermittent supervision or reminders (i.e. cuing or guidance only).
- Needs physical assistance, but child is able to participate. Excludes car seat, highchair, crib for toddler age child. (N/A 0-30 months)
- Needs total assistance of another and child is physically unable to participate. (N/A 0-18 months)
- Must be transferred using a mechanical device (i.e. Hoyer lift)

**Challenges – What difficulties does the person have with making transfers?**

- Behavioral issues
- Afraid of falling
- Afraid of Hoyer lift
- Disease/symptoms interfere with performing task
- Two-person transfer
- Unable to transfer without assistance
- Unsteady during transfer
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

**Strengths – What does the person do well when transferring?**

- Asks for assistance
- Aware of safety
- Can transfer self-using a lift
- Cooperates with caregiver
- has good upper body strength
- Motivated
- Transfers with some support
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Preferences – What does the person prefer when making transfers?

- Caregivers use a gait belt
- Family member to assist
- Manual lifts
- Use a transfer board
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Support Instructions – What helps the most when assisting the person with transfers?

- Manage their own need
- Assist all wheelchair transfers
- Cue to use adaptive equipment
- maintain contact until steady
- Talk person through each transfer
- Transfer quickly
- Transfer slowly
- Use Hoyer for transfers
- Use transfer board for transfers
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Comments: \_\_\_\_\_

### Is training needed to increase independence?

- No
- Yes

Comments: \_\_\_\_\_

Notes/Comments: \_\_\_\_\_

### Transfers ADL has been assessed? *(Displays for reassessment only)*

- Yes



## Transfers Equipment

Does the person have or need any adaptive equipment to assist with transfers?

- No
- Yes
- Chose not to answer

Comments: \_\_\_\_\_

*If 'Yes' was selected, the 'Transfer Equipment Status' table will be displayed:*

### Transfer Equipment Status *(Select All that Apply)*

Type	Has and Uses	Has and does not use	Needs	Comments/Supplier
Bed rail	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Brace	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Ceiling lift track system	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Draw sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Electronic bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Gait belt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Hoyer or similar device	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Lift chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Slide board	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Specialized medical equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: (text box)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: (text box)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

Notes/ Comments: \_\_\_\_\_

## Referrals & Goals (ADLs)

What is important to the individual? \_\_\_\_\_

### Referrals Needed:

- Assistance with Personal Care  
\_\_\_\_\_ *(Displays if checked)*
- Assistive Technology  
\_\_\_\_\_ *(Displays if checked)*
- Environmental Accessibility Consultation  
\_\_\_\_\_ *(Displays if checked)*
- Equipment and Supplies  
\_\_\_\_\_ *(Displays if checked)*
- Nutritionist/Dietician  
\_\_\_\_\_ *(Displays if checked)*
- Occupational Therapist  
\_\_\_\_\_ *(Displays if checked)*
- Physical Therapist  
\_\_\_\_\_ *(Displays if checked)*
- Primary Health Care Provide  
\_\_\_\_\_ *(Displays if checked)*
- Other **Specify:** \_\_\_\_\_ *(Displays when 'Other' is checked)*
- Other **Specify:** \_\_\_\_\_ *(Displays when 'Other' is checked)*

**Summarize each need with the associated support plan implication to meet the need and any notes on referrals**

**Referrals & Goals (ADLs) have been assessed?** *(Displays for reassessment only)*

- Yes