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

Limited physical assistance:
Staff or caregiver provides partial physical assistance to accomplish the task; person is highly involved in the activity.

Extensive/Total dependence:
Staff or caregiver fully assists the person in accomplishing the task; person is unable to or minimally participates.
Eating

Does the person have any difficulties with eating or require support or assistance with eating?

- No
- Yes
- Sometimes
- Chose not to answer

(If ‘Yes’ or ‘Sometimes’ is 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

Does the person need assistance on a daily basis or on days during the week when the activity is completed?

- No
- Yes
Assessment Domains

(Displays only if Age >= 18)

In regard to the ability to manage eating by themself, this person:

- 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 <= 17)

- 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.

Challenges - What difficulties does the person have with 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 __________________ (Displays when this option is checked)
- Other __________________ (Displays when this option is checked)

Comments: ____________________________
Assessment Domains

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 _______________ (Displays when this option is checked)
☐ Other _______________ (Displays when this option is checked)

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 _______________ (Displays when this option is checked)
☐ Other _______________ (Displays when this option is checked)

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 _______________ (Displays when this option is checked)
- ☐ Other _______________ (Displays when this option is checked)

Comments: ________________________________

Is training/skill building needed to increase independence?
- ☐ No
- ☐ Yes

Notes/ Comments:

__________________________________________

Eating ADL has been reviewed and updated?
- ☐ Yes
Eating Equipment

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

- ☐ No
- ☐ Yes
- ☐ Chose not to answer

*If Yes is selected, the following ‘Eating Equipment Status’ table will be displayed:*

Eating Equipment Status

Check all that apply:

<table>
<thead>
<tr>
<th>Type</th>
<th>Has and Uses</th>
<th>Has and does not use</th>
<th>Needs</th>
<th>Comments/Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapted cup</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Adapted utensils</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Dentures</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Dycem mat</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Gastrostomy tube</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Hickman catheter</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Jejunostomy tube</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Nasogastric tube</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Plate guard</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Specialized medical equipment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Straw</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other ___________</td>
<td>☐</td>
<td>☐</td>
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<td></td>
</tr>
<tr>
<td>Other ___________</td>
<td>☐</td>
<td>☐</td>
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<td></td>
</tr>
</tbody>
</table>

Notes/Comments:

__________________________________________________________________________________________
Bathing

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

- No
- Yes
- Sometimes
- Chose not to answer

*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

Does the person need assistance on a daily basis or on days during the week when the activity is completed?

- 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
Assessment Domains

- 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 ___________________ *(Displays when this option is checked)*
- Other ___________________ *(Displays when this option is checked)*

Comments: ________________________________
Assessment Domains

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 _____________ (Displays when this option is checked)
- Other _____________ (Displays when this option is checked)

Comments: ________________________________________________

Preferences – What does the person prefer when bathing?

- Bath
- Bed bath
- Female caregiver
- Male caregiver
- Shower
- Sponge bath
- Use specific products
- Other _____________ (Displays when this option is checked)
- Other _____________ (Displays when this option is checked)

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 __________________ (Displays when this option is checked)
☐ Other __________________ (Displays when this option is checked)

Comments: ________________________________

Is training needed to increase independence?

☐ No
☐ Yes

Notes/Comments

________________________________________________________________________

Bathing ADL has been reviewed and updated?

☐ Yes
Bathing Equipment

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

- No
- Yes
- Chose not to answer

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

### Bathing Equipment Status

Check all that apply:

<table>
<thead>
<tr>
<th>Type</th>
<th>Has and Uses</th>
<th>Has and does not use</th>
<th>Needs</th>
<th>Comments/Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bath bench</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>Grab bars</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>Hand-held shower</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>Hoyer Lift</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>Roll-in shower chair</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>Shower chair</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>Specialized medical</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer bench</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
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<tr>
<td>Other</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
</tbody>
</table>

**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

*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

Does the person need assistance on a daily basis or on days during the week when the activity is completed?

- 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 ____________________ *(Displays when this option is checked)*
- [ ] Other ____________________ *(Displays when this option is checked)*

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 [ ] (Displays when this option is checked)
- Other [ ] (Displays when this option is checked)

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 [ ] (Displays when this option is checked)
- Other [ ] (Displays when this option is checked)

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 [ ] (Displays when this option is checked)
- Other [ ] (Displays when this option is checked)

Comments: ________________________________

Is training needed to increase independence?
Assessment Domains

○ No
○ Yes

Notes/Comments:

Dressing ADL has been reviewed and updated?

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

- No
- Yes
- Chose not to answer

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

### Dressing Equipment Status

Check all that apply:

<table>
<thead>
<tr>
<th>Type</th>
<th>Has and Uses</th>
<th>Has and does not use</th>
<th>Needs</th>
<th>Comments/Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapted clothing</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Button hook</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
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<tr>
<td>Elastic shoe laces</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
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<tr>
<td>Helmet</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
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<tr>
<td>Orthotics</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Prosthesis</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Protective gear</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Reacher</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
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<tr>
<td>Sock aid</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Specialized medical equipment</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>TED hose</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
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<td>Other _____________</td>
<td>O</td>
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<td>Other _____________</td>
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</tr>
</tbody>
</table>

**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

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

Does the person need assistance on a daily basis or on days during the week when the activity is completed?

- No
- Yes
In regard to the ability to manage grooming activities, this person:

- 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:

- 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 __________________ (Displays when this option is checked)
- Other __________________ (Displays when this option is checked)

Comments: __________________________________________________________
Assessment Domains

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 ________________ (Displays when this option is checked)
☐ Other ________________ (Displays when this option is checked)

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 ________________ (Displays when this option is checked)
☐ Other ________________ (Displays when this option is checked)

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 ____________ (Displays when this option is checked)
- Other ____________ (Displays when this option is checked)

Comments: ____________________________________________

Is training needed to increase independence?

- No
- Yes

Notes/Comments:

________________________________________________________

Personal Hygiene/Grooming ADL has been reviewed and updated?

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

○ No
○ Yes
○ Chose not to answer

*If ‘Yes’ was selected, the following ‘Personal hygiene’ table will be displayed:*

## Hygiene Equipment Status

Check all that apply:

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<thead>
<tr>
<th>Type</th>
<th>Has and Uses</th>
<th>Has and does not use</th>
<th>Needs</th>
<th>Comments/Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapted toothbrush</td>
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<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Dental floss holder/flossing aid</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Dentures</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Electric razor</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
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<tr>
<td>Special type of toothbrush</td>
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<tr>
<td>Splint</td>
<td>○</td>
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<td>○</td>
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<td>Other</td>
<td>○</td>
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</tr>
</tbody>
</table>

### 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

*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

Does the person need assistance on a daily basis or on days during the week when the activity is completed?

- [ ] No
- [ ] Yes
(Displays only if Age >= 18)

In regard to the ability to manage using the toilet, this person:

- 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

(Displays only if Age <= 17)

In regard to the ability to manage using the toilet, this child:

- 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 ____________________________ (Displays when this option is checked)
- Other ____________________________ (Displays when this option is checked)

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 ______________ (Displays when this option is checked)  
☐ Other ______________ (Displays when this option is checked)  

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 ______________ (Displays when this option is checked)  
☐ Other ______________ (Displays when this option is checked)  

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 ____________________ *(Displays when this option is checked)*
- Other ____________________ *(Displays when this option is checked)*

Comments: ____________________________________________

Is training needed to increase independence?

- No
- Yes

Notes/Comments:

_____________________________________________________________________

Toileting ADL has been reviewed and updated?

- Yes
Assessment Domains

Toilet Use/Continence Support Equipment

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

- No
- Yes
- Chose not to answer

*If ‘Yes’ was selected, the following ‘Toilet Use Equipment Status’ table will be displayed:*

**Toilet Use Equipment Status**
Check all that apply:

<table>
<thead>
<tr>
<th>Type</th>
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<th>Has and does not use</th>
<th>Needs</th>
<th>Comments/Supplier</th>
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<tr>
<td>Barrier cream</td>
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<tr>
<td>Bed pan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incontinence briefs/pads</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Colostomy bag</td>
<td></td>
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</tr>
<tr>
<td>Commode</td>
<td></td>
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<tr>
<td>Disinfectant spray</td>
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</tr>
<tr>
<td>External catheter</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Gloves</td>
<td></td>
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<tr>
<td>Grab bars</td>
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<tr>
<td>Ileostomy bag</td>
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<tr>
<td>Internal catheter</td>
<td></td>
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</tr>
<tr>
<td>Mattress cover</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Raised toilet seat</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Specialized medical equipment</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Urinal</td>
<td></td>
<td></td>
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<tr>
<td>Other __________</td>
<td></td>
<td></td>
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<tr>
<td>Other __________</td>
<td></td>
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</tbody>
</table>

**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

*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 selected above)*

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

- No
- Yes

**Does the person need assistance on a daily basis or on days during the week when the activity is completed?**

- 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 ____________________ *(Displays when this option is checked)*
- Other ____________________ *(Displays when this option is checked)*

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 _______________  *(Displays when this option is checked)*
- Other _______________  *(Displays when this option is checked)*

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 _______________  *(Displays when this option is checked)*
- Other _______________  *(Displays when this option is checked)*

Comments: ____________________________________________
Assessment Domains

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 ____________ (Displays when this option is checked)
- Other ____________ (Displays when this option is checked)

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 ____________ (Displays when this option is checked)
- Other ____________ (Displays when this option is checked)

Comments: _______________________________________
Preferences – What does the person prefer to get around their community?

- Contact guard
- Outings in the afternoon
- Outings in the morning
- Wheelchair
- Other ______________ (Displays when this option is checked)
- Other ______________ (Displays when this option is checked)

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 ______________ (Displays when this option is checked)
- Other ______________ (Displays when this option is checked)

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 __________________________ (Displays when this option is checked)
- Other __________________________ (Displays when this option is checked)

Comments: __________________________

Is training/skill building needed to increase independence?

- No
- Yes

Notes/Comments:

________________________________________

Mobility – Walking and Wheeling ADL has been reviewed and updated?

- 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

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

## Mobility Equipment Status

Check all that apply:

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<thead>
<tr>
<th>Type</th>
<th>Has and Uses</th>
<th>Has and does not use</th>
<th>Needs</th>
<th>Comments/Supplier</th>
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<td>Crutch</td>
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<td>Gel pad</td>
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<td>Manual wheelchair</td>
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<tr>
<td>Motorized wheelchair</td>
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<tr>
<td>Prostheses</td>
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<tr>
<td>Quad cane</td>
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<td>Service animal</td>
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<td>Splint/Braces</td>
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<td>Walker</td>
<td>O</td>
<td>O</td>
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<td></td>
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<td>Walker with seat</td>
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</tr>
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<td>Other</td>
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<tr>
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</tr>
</tbody>
</table>

**Notes/Comments:**

____________________________________________________________________

Last update: 6/12/2017
Positioning

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

- No
- Yes
- Sometimes
- Chose not to answer

*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

Does the person need assistance on a daily basis or on days during the week when the activity is completed?

- No
- Yes
(Displays only if Age >= 18)
**In regard to the ability to manage sitting up or moving around, this person**
- ○ 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

(Displayed only if Age <= 17)
**In regard to the ability to manage turning and positioning, this child**
- ○ 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 _______________ *(Displays when this option is checked)*
- □ Other _______________ *(Displays when this option is checked)*

Comments: ___________________________________________
Assessment Domains

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 __________________ (Displays when this option is checked)
☐ Other __________________ (Displays when this option is checked)

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 ______________ (Displays when this option is checked)
☐ Other ______________ (Displays when this option is checked)

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 ___________ (Displays when this option is checked)
- Other ___________ (Displays when this option is checked)

Comments: ___________________________________________

Is training/skill building needed to increase independence?

- No
- Yes

Notes/Comments:

__________________________________________________________

Positioning ADL has been reviewed and updated?

- Yes
Positioning Equipment

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

- ○ No
- ○ Yes
- ○ Chose not to answer

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

### Positioning Equipment Status

Check all that apply:

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<th>Type</th>
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<th>Has and does not use</th>
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<th>Comments/Supplier</th>
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<td>Brace</td>
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<tr>
<td>Electronic bed</td>
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<td>Flotation mattress</td>
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<td>Manual bed</td>
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</tr>
<tr>
<td>Posey or other enclosed bed</td>
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<tr>
<td>Side rails</td>
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<td></td>
</tr>
</tbody>
</table>

**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

*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

Does the person need assistance on a daily basis or on days during the week when the activity is completed?

- 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, and 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 __________________ (Displays when this option is checked)
- Other __________________ (Displays when this option is checked)

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 _______________ *(Displays when this option is checked)*
- [ ] Other _______________ *(Displays when this option is checked)*

**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 _______________ *(Displays when this option is checked)*
- [ ] Other _______________ *(Displays when this option is checked)*

**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 _______________ *(Displays when this option is checked)*
- [ ] Other _______________ *(Displays when this option is checked)*

**Comments:** ____________________________________________
Is training needed to increase independence?

- No
- Yes

Notes/Comments:

Transfers ADL has been reviewed and updated?

- Yes
Transfers Equipment

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

- No
- Yes
- Chose not to answer

If ‘Yes’ was selected, the ‘Transfer Equipment Status’ table will be displayed:

**Transfer Equipment Status**
Check all that apply:

<table>
<thead>
<tr>
<th>Type</th>
<th>Has and Uses</th>
<th>Has and does not use</th>
<th>Needs</th>
<th>Comments/Supplier</th>
</tr>
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<tbody>
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<td>Bed rail</td>
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<td></td>
</tr>
<tr>
<td>Brace</td>
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<tr>
<td>Ceiling lift track system</td>
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<td>Draw sheet</td>
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<td>Electronic bed</td>
<td>o</td>
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<td>Gait belt</td>
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<td>Hoyer or similar device</td>
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<tr>
<td>Lift chair</td>
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<td>Slide board</td>
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<td>Trapeze</td>
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**Notes/Comments:**

__________________________________________________________________
Referrals & Goals (Psychosocial)

What is important to the individual?

Referrals Needed:

- ☐ Assistance with Personal Care
- ☐ Assistive Technology
- ☐ Environmental Accessibility Consultation
- ☐ Equipment and Supplies
- ☐ Nutritionist/Dietician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Primary Health Care Provider
- ☐ Other
- ☐ Other

Assessed Needs and Support Plan Implications

Referrals & Goals - ADLs have been reviewed and updated?

- ☐ Yes