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
Assessment Domains

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 themself, 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:
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:
  ☐ 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):

<table>
<thead>
<tr>
<th>Type</th>
<th>Has and Uses</th>
<th>Has and does not use</th>
<th>Needs</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapted cup</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Adapted utensils</td>
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<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>
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<td>○</td>
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</tr>
<tr>
<td>Plate guard</td>
<td>○</td>
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<tr>
<td>Specialized medical equipment</td>
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<tr>
<td>Straw</td>
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<td>Other:</td>
<td>○</td>
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<tr>
<td>Other:</td>
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<td></td>
</tr>
</tbody>
</table>

Notes/Comments: ____________
Assessment Domains

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):**

<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>
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<td>☐</td>
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<tr>
<td>Grab bars</td>
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<td>☐</td>
<td></td>
</tr>
<tr>
<td>Hand-held shower</td>
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<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Hoyer Lift</td>
<td>☐</td>
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<td>☐</td>
<td></td>
</tr>
<tr>
<td>Roll-in shower chair</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Shower chair</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Specialized medical</td>
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<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer bench</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other: __________</td>
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<td>Other: __________</td>
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<td></td>
</tr>
</tbody>
</table>

Notes/Comments: __________
Assessment Domains

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


**Assessment Domains**

**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: __________
Assessment Domains

**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: __________*
Assessment Domains

Is training needed to increase independence?

- No
- Yes

Comments: __________

Notes/Comments:

__________

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

- Yes
Assessment Domains

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)*:

<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>☐</td>
<td>☐</td>
<td>☐</td>
<td>____________</td>
</tr>
<tr>
<td>Button hook</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>____________</td>
</tr>
<tr>
<td>Elastic shoe laces</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>____________</td>
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<tr>
<td>Helmet</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>____________</td>
</tr>
<tr>
<td>Orthotics</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>____________</td>
</tr>
<tr>
<td>Prosthesis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>____________</td>
</tr>
<tr>
<td>Protective gear</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>____________</td>
</tr>
<tr>
<td>Reacher</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>____________</td>
</tr>
<tr>
<td>Sock aid</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>TED hose</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>____________</td>
</tr>
<tr>
<td>Other: ____________</td>
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<td>____________</td>
</tr>
</tbody>
</table>

☐ Notes/Comments: ____________
Assessment Domains

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
Assessment Domains

In regard to the ability to manage grooming activities, this child
(Displayed 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: _________
Assessment Domains

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)**

<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 toothbrush</td>
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<td>o</td>
<td>o</td>
<td>__________</td>
</tr>
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<td>Dental floss holder/flossing aid</td>
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<td>o</td>
<td>o</td>
<td>__________</td>
</tr>
<tr>
<td>Dentures</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>__________</td>
</tr>
<tr>
<td>Electric razor</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>__________</td>
</tr>
<tr>
<td>Special type of toothbrush</td>
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<td>o</td>
<td>o</td>
<td>__________</td>
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<td>Splint</td>
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<td>o</td>
<td>__________</td>
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<tr>
<td>Other: __________</td>
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<td>__________</td>
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<tr>
<td>Other: __________</td>
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<td>o</td>
<td>__________</td>
</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

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: ________
Assessment Domains

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/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

Comments: __________

If ‘Yes’ was selected, the ‘Hygiene Equipment Status’ table will display:

**Hygiene Equipment Status (Select 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>
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<td>Barrier cream</td>
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<td>Incontinence briefs/pads</td>
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<td>Colostomy bag</td>
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<td>__________</td>
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<td>Commode</td>
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<td>__________</td>
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<td>Disinfectant spray</td>
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<td>External catheter</td>
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<td>O</td>
<td>__________</td>
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<td>Gloves</td>
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<td>__________</td>
</tr>
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<td>Grab bars</td>
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<td>O</td>
<td>__________</td>
</tr>
<tr>
<td>Ileostomy bag</td>
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<td>O</td>
<td>O</td>
<td>__________</td>
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<td>Internal catheter</td>
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<td>O</td>
<td>__________</td>
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<td>O</td>
<td>__________</td>
</tr>
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<td>Raised toilet seat</td>
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<td>__________</td>
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<td>__________</td>
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<td>__________</td>
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<td>Other: __________</td>
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<td>O</td>
<td>O</td>
<td>__________</td>
</tr>
</tbody>
</table>

Notes/Comments: __________
Assessment Domains

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: __________
Assessment Domains

**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: __________

Last update: 06/04/2014
Assessment Domains

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):

<table>
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<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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</tr>
<tr>
<td>Cane</td>
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</tr>
<tr>
<td>Crutch</td>
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<td>Gait belt</td>
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<tr>
<td>Gel pad</td>
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<tr>
<td>Manual wheelchair</td>
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<td>Motorized wheelchair</td>
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<td>Prostheses</td>
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<td>Quad cane</td>
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<td>Ramps</td>
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<td>Scooter</td>
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<tr>
<td>Specialized medical equipment</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Splint/Braces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Walker with seat</td>
<td></td>
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<td>Other: __________</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Notes/Comments: __________

Last update: 06/04/2014
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
Assessment Domains

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: __________
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 __________
☐ 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):

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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>
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<tbody>
<tr>
<td>Alternating pressure mattress</td>
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<tr>
<td>Bubble mattress</td>
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<tr>
<td>Brace</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Electronic bed</td>
<td>O</td>
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<td></td>
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<tr>
<td>Flotation mattress</td>
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<td>Manual bed</td>
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<td>Posey or other enclosed bed</td>
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<td>Side rails</td>
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<td>Water mattress</td>
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<td>O</td>
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</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

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
Assessment Domains

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: ___________
Assessment Domains

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)*

<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>
<tr>
<td>Bed rail</td>
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<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></td>
</tr>
<tr>
<td>Electronic bed</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Gait belt</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Hoyer or similar device</td>
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</tr>
<tr>
<td>Lift chair</td>
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<td>Slide board</td>
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</tr>
</tbody>
</table>

**Notes/ Comments:**

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Last update: 06/04/2014
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 Provider
  ________________________________ (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