



APPENDIX 3

Referral for assessment by Care and Repair

Client Name: Telephone No: Mobile:	Access Arrangements/Directions:
Address: Post Code:	Tenure: O-O Private tenant RSL: Eildon SBHA Waverley Berwickshire <i>Please highlight</i>
Date of Birth:	Safety Alert:
Medical/health condition relating to need for assessment:	
Identified need for assessment (brief description):	
Options appraisal (has equipment, minor adaptation, reablement already been considered?):	
Is the client aware that they are being referred to C & R for a screening assessment: <p style="text-align: right;">Yes No</p>	
Assessment requested by: Address: Telephone No: Date:	Designation:
To: Borders Care & Repair The Weaving Shed Ettrick Mill Dunsdale Road Selkirk TD7 5EB	Care & Repair Use Date added to Waiting List: Date Actioned: Case Ref No:

Email: enquiries@borderscareandrepair.org.uk
 (Remember to encrypt with the agreed password)

 <p>Caring, Committed, Connected, Creative</p>	Date received:			
	Accept:	Case no:		
	Unable to accept:	Reason:		
	Action:			
Screening Form				
Title: Mr / Mrs / Miss / Ms	Date of birth:	M / F		
Surname:	First name:			
Address:	Telephone:			
Postcode:				
<u>Property details:</u> Owner Occupier <input type="checkbox"/> Private rented <input type="checkbox"/> Housing association (please state):				
Type of property (bungalow, flat, sheltered housing etc):				
Which rooms do you have:				
	Kitchen	Kitchen/Diner	Dining room	
	Lounge/Diner	Lounge		
Bathroom:	Same floor	Downstairs	Upstairs	Both
Toilet:	Same floor	Downstairs	Upstairs	Both
Bedrooms:	1 2 3	4		
Other:				
Stairs:	Straight	Curved		
Stair rails:	None	One side	Both sides	
Do you live alone? Yes/No	If No, who with?			
Disability or long-term medical condition, please specify:				
Do you receive any care at home? Yes / No				
Is this a formal package of care? Yes / No	If Yes, how many hours per week?			
Is this informal care? e.g. family member, neighbour etc. Yes / No	If Yes, can you estimate how many hours per week?			
What kind of help do you receive? e.g. help with personal care, domestic tasks etc.				
Do you use a mobility aid or wheelchair? Please specify:	Yes / No			

Do you have any equipment or adaptations to help at home? Please specify

Let us know which activities are a problem for you and which you can manage.
 Please TICK the column which applies to you most.

	Not applicable	Able to do	Able to do – with help from another person	Able to do with equipment	Unable to do / have difficulty doing
Walking indoors					
Up/downstairs indoors					
Outdoors steps/stairs					
Going to the toilet					
Getting on/off the toilet					
Getting to your bed					
Getting in/out bed					
Getting in/out chair					
Getting washed					
Getting in/out bath					
Using walk-in shower					
Getting dressed					

Have you fallen recently? Yes / No
 If yes, please provide details:

Any other relevant information:

Process for referring clients to Care and Repair for assessment via the pilot project:



Is the identified need a structural housing issue? (bathroom adaptation, stair lift, ramp etc)	If yes, go to next question. If no – not appropriate for Care and Repair pilot scheme
Has equipment provision been considered as a potential solution?	If yes – go to next question If no – go to locality SC&H
Is reablement appropriate?	If yes – go to locality SC&H If no – go to next question
Is there a need for a wider OT assessment?	If yes – go to locality SC&H If no – consider referral to Care and Repair pilot scheme

Borders Care & Repair Pilot Project



Discharge summary

Name:
Address:
Date of referral:
Assessment date:
Completion date:
Reason for referral:
Outcome of assessment:
Other actions required:
Signed:
Date:

Pilot project – assessment process:
 Pilot project - assessment process:



Referral received	Allocate case no.	
Initial client contact	Appropriate – yes/no	
Screening form	Sent out for completion or home visit	
Assessment	Home visit; gathering other relevant information; collaboration with health professionals etc. (consent required)	
Risk assessment	Complete risk assessment: include interim recommendations on client assessment.	
Outcome	Major adaptation	OT/ Projects Officer: C&R process
	Rehabilitation	Refer to SC&H
	Trial of equipment	OTA at C&R*
	Minor adaptation	OTA at C&R*
	Advice; information; signposting	OT at C&R
Objectives agreed with client	Scores obtained using COPM	
Assessment to client for sign off	Include interim recommendations.	
Base line data recorded	Using ACT and XL spreadsheet	
Adaptation process	OT/Projects Officer: C&R process	
Completion of works		
Review – re-assess	Scores obtained using COPM	
Follow-up data recorded	Using ACT and XL spreadsheet	
Discharge summary	Any other actions/ forward referrals	