

# Supported Accommodation Service Resident's Assessment Form

(for completion by the resident's  
doctor, and review every 6 months,  
see Form 2A)

## Form 2 Schedule to Form 1 Resident's Details

Resident's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Male / Female

Supported Residential Service: Tarampa Lodge Pty Ltd  
449 Lowood/Minden Road  
TARAMPA QLD 4311

Tick the column which describes the resident's needs in each area

Activity	No Assistance Required	Individual Prompting & Supervision	Physical Assistance Required	Details / Comments
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### 1 Health Needs

#### Cognition & Perception

* orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* wandering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* personal safety <i>(use household appliances / emergency response / stranger treatment)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

#### Health Issues

* taking medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* other regular health needs <i>(diabetics, wound dressings, nebuliser, epilepsy)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* personal injury <i>(ability to attend to minor first aid and/or seek assistance)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* medical <i>(ability to recognise need for medical intervention and initiate assistance)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

#### Night Support

* safe practices <i>(turning off appliances, lock premises, emergency responses)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* sleeping patterns <i>(go to bed sleep through night)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* physical supports <i>(continence etc)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* behavioural issues <i>(requires staff prompting supervision to limit impact)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

#### Behaviour Support

	(Pls Circle)	Comments
* behaviour issues	yes / no	
* absconding/wandering	yes / no	
* aggressive towards others	yes / no	
* self injury	yes / no	
* physically assaultive towards others	yes / no	
* other behavioural issues <i>(describe)</i>		

Activity	No Assistance Required	Individual Prompting & Supervision	Physical Assistance Required	Details / Comments
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**2 Daily Living Activities** (2.1 of Quality of Care Principles of 1997)

**Personal Hygiene**

* bathing / showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* personal hygiene (teeth cleaning, shaving)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Continence**

* managing continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* continence aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Eating**

* eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* eating aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Dressing**

* dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* undressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* dressing aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Mobility**

* ambulation (walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* transfers (moving between sitting / standing / lying)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* negotiating stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* mobility aids (wheelchair / frame / cane)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* use of safety devices (eg: handrails)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* use of transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Communication**

Pls Circle Appropriate Assessment

* speech	<input type="checkbox"/> coherent	<input type="checkbox"/> slurred	<input type="checkbox"/> aphasic	<input type="checkbox"/> communication aid	<input type="checkbox"/> requires assistance to maintain aids
* hearing	<input type="checkbox"/> no loss	<input type="checkbox"/> aid	<input type="checkbox"/> deafness	<input type="checkbox"/> requires assistance to maintain aids	
* eyesight	<input type="checkbox"/> good	<input type="checkbox"/> glasses	<input type="checkbox"/> failing	<input type="checkbox"/> blind	<input type="checkbox"/> requires assistance to maintain aids
* recognition	<input type="checkbox"/> family	<input type="checkbox"/> friends	<input type="checkbox"/> unresponsive		

No Assistance Required	Individual Prompting & Supervision	Physical Assistance Required	Details / Comments
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* general communication needs (ability to express concepts and needs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* use of telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
* writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

(Pls Circle)

Comments

**3 NURSING SERVICES** (3.8 of Quality of Care Principles 997)

* assessment and planning of care by Registered Nurse	<input type="checkbox"/> yes / <input type="checkbox"/> no	<input type="text"/>
* management of care carried out by Registered Nurse	<input type="checkbox"/> yes / <input type="checkbox"/> no	<input type="text"/>
* nursing services (eg: pain management, wound management, etc)	<input type="checkbox"/> yes / <input type="checkbox"/> no	<input type="text"/>

**4 Other Comments / Medical Issues**

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**5 Paramedical Needs** (eg speech pathologist, physiotherapist, etc)

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<p style="text-align: center;"><i>I certify that this resident requires continuous assistance with above assessed care services .</i></p>	<p>signed _____</p> <p>name _____</p> <p>provider nos. _____</p> <p>date _____</p>
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(Note to meet the requirements for services to be GST free, a resident must be assessed as needing, on a continuous basis, either physical assistance or supervision / prompting with one of the services listed under daily living activities (2) or nursing services (3).

