self-directed assessment questionnaire

NHS Number:
Ref or other identifier:

About your assessment

Your assessment will provide a record of your social care needs and priorities. You can complete it yourself or a social care professional will help you. You may want a member of your family or a carer to be involved in completing your assessment.

At the start of the assessment you can record details about yourself and the reason for your assessment. During your assessment you will be asked about:

1. Seeing, hearing and communicating
2. Looking after yourself
3. Getting around
4. Managing your home and money
5. Your accommodation and income
6. Your safety
7. Staying healthy
8. Your mental health and wellbeing
9. Leisure, interests, hobbies and your community
10. Work and learning opportunities
11. Caring and parenting
12. Other information which you think is important.

As you complete your assessment you can record the issues identified, how important they are to you, whether you think action is needed and what you hope will change as a result. Social care professionals may ask you further questions to identify the need for action or referrals.

The information recorded during the assessment will be used by you and the professionals involved in your care to agree a plan to improve your health, independence and wellbeing and to calculate an indicative budget to spend on your support. This will include details of services to be provided, referrals and actions that you or your carers have agreed to take.

You are entitled to keep a copy of your assessment information, and you will be asked to give your consent for your assessment information to be shared with others involved in your care.

Biography

Please tell us about yourself. It can be helpful to record things like your life story, your occupation, your interests …
In your own words, describe why you think this assessment is taking place. Answering the following questions may be helpful. What are your current needs and concerns? How long have you experienced them? What solution do you have in mind? What do you hope will change as a result of this assessment?

Name of Assessor:	Signature of Assessor:	Date:

1. Seeing, hearing and communicating

1.1 Can you see (with glasses if worn)?

Yes ☐ With difficulty ☐ Cannot see at all ☐

1.2 Can you hear (with a hearing aid if worn)?

Yes ☐ With difficulty ☐ Cannot hear at all ☐

1.3 Do you have difficulty in making yourself understood because of problems with your speech?

No difficulty ☐ Difficulty with some people ☐ Considerable difficulty with everyone ☐

1.4 Can you use the telephone?

Without help (including looking up numbers and dialling) ☐ With some help ☐ Or are you unable to use the telephone ☐

1.5 Do you need someone with specialist skills or specialist equipment to help you communicate?

Yes ☐ No ☐

COMMENTS

What issues have been identified?

Signature of assessor: Date: Customer reference:

Seeing, hearing and communicating, continued

How important are they to you?

Do you need to take any action?

What do you hope will change as a result?

Signature of assessor: Date: Customer reference:

If you have answered "Yes" to question 1.5 please state your level of need in this area

How much help do you need to communicate with other people? (e.g. because of a speech, visual or hearing impairment)

a) I do not need help with communication ☐

b) My communication needs can be met with equipment or communication aids ☐

c) I need someone with specialist skills to give support for up to **2 hours per week** to meet my communication needs ☐

d) I need someone with specialist skills to give support for **2 to 6 hours per week** to meet my communication needs ☐

e) I need someone with specialist skills to give support for **7 to 14 hours per week** to meet my communication needs ☐

f) I need someone with specialist skills to give support for **15 or more** hours per week to meet my communication needs ☐

Signature of assessor: _____ Date: _____ Customer reference: _____

2. Looking after yourself

2.1 Can you keep up your personal appearance (e.g. brush your hair, shave, put makeup on etc…)?

Without help ☐ Need help keeping up personal appearance ☐

2.2 Can you dress yourself?

Without help ☐ (including buttons, laces etc.) With some help ☐ (can do half unaided) Unable to dress myself ☐

2.3 Can you wash your hands and face?

Without help ☐ Need help ☐

2.4 Can you use the bath or shower?

Without help ☐ Need help ☐

If you have chosen 'Need help' *please specify:*

COMMENTS

What issues have been identified?

Signature of assessor: Date: Customer reference:

How important are they to you?

Do you need to take any action?

What do you hope will change as a result?

Looking after yourself, continued

2.5 Can you prepare your own meals?

Without help (plan and cook full meals yourself) ☐

With some help (can prepare things but unable to cook full meals yourself) ☐

Unable to prepare meals ☐

2.6 Can you feed yourself?

Without help ☐

With some help (cutting up food, spreading butter etc) ☐

Unable to feed yourself ☐

2.7 Do you have problems with your mouth or teeth?

No ☐

Yes ☐

If YES *please specify:*

2.8 Have you had any problems with your skin (e.g. leg ulcers, pressure sores)?

Yes ☐

No ☐

If YES *please specify:*

2.9 Can you take your own medicine?

Without help (in the right doses and right times) ☐

With some help (someone prepares it for you and/or reminds you) ☐

Unable to take own medicine ☐

Signature of assessor: _____ Date: _____ Customer reference: _____

Looking after yourself, continued

2.10 Do you have accidents with your bladder (incontinence of urine)?

No accidents ☐

Yes occasionally (less than once a day) ☐

Frequently (once a day or more) or need help with a urinary catheter ☐

2.11 Do you have accidents with your bowels (incontinence of faeces)?

No accidents ☐

Yes occasionally (less than once a week) ☐

Frequently (once a day or more) or need to be given an enema ☐

2.12 Can you use the toilet (or commode)?

Without help ☐ (can reach toilet or commode, undress sufficiently, clean self and leave)

With some help ☐ (can do some things including wiping self)

Unable to use toilet or commode ☐

2.13 Do you need or use any specialist equipment to help you look after yourself?

Yes ☐

No ☐

COMMENTS

What issues have been identified?

Signature of assessor: _____ Date: _____ Customer reference: _____

Looking after yourself, continued

How important are they to you?

Do you need to take any action?

What do you hope will change as a result?

Signature of assessor: Date: Customer reference:

What is your level of need in this area?

How much help do you need to look after yourself – things like ensuring you eat and drink regularly, washing, dressing and going to the toilet?

a) I do not need help to look after myself ☐

b) I am able to do most things I need to do to look after myself; however I need prompting now and then ☐

c) I am able to do most things I need to do to look after myself; however I need help with showering/bathing or help with meals preparation ☐

d) I am able to do some things I need to do to look after myself; however I need daily help or prompting and encouragement ☐

e) I need a lot of help every **day** to look after myself; however I can manage this with the support of **1 person** ☐

f) I need a lot of help every **day** to look after myself; however I can manage this with the support of **2 people** ☐

g) I need a lot of help every **day and night** to look after myself; however I can manage this with the support of **1 person** ☐

h) I need a lot of help every **day and night** to look after myself; however I can manage this with the support of **2 people** ☐

Signature of assessor: Date: Customer reference:

3. Getting around

3.1 Can you move from bed to chair if they are next to each other?

Without help ☐ With some help ☐ Unable to move from bed to chair ☐

3.2 Do you have any problems with your feet?

No problems ☐ Some problems ☐

If you answered 'some problems' *please specify:*

3.3 Can you get around indoors?

Without help ☐ In a wheelchair without help ☐ With some help ☐ Confined to bed ☐

3.4 Can you manage stairs?

Yes (including carrying any walking aid) ☐ With some help ☐ Unable to manage stairs ☐

3.5 Have you had any falls in the last twelve months?

None ☐ One ☐ Two or more ☐

3.6 Can you walk outside?

Without help ☐ With some help ☐ Unable to walk outside ☐

3.7 Do you have difficulty getting to public services (doctor, pharmacy, dentist etc.)?

No difficulty ☐ With some help ☐ Unable to get to public services ☐

3.8 Can you use public transport?

Without help ☐ With some help ☐ Unable to use public transport ☐

Signature of assessor: _____ Date: _____ Customer reference: _____

COMMENTS

What issues have been identified?

How important are they to you?

Do you need to take any action?

What do you hope will change as a result?

Signature of assessor: Date: Customer reference:

4. Managing your home and money

4.1 Can you do your housework?

Without help (clean floors etc.) ☐

With some help (can do light house-work, but need help with heavy work) ☐

Unable to do any housework ☐

4.2 Can you go shopping?

Without help (taking care of all shopping needs) ☐

With some help (need someone to go on all shopping trips with you) ☐

Unable to go shopping ☐

4.3 Are you able to manage your money and financial affairs?

Without help ☐

With some help ☐

Unable to manage finances ☐

4.4 Does someone manage your financial affairs with lasting power of attorney?

Yes ☐

No ☐

COMMENTS

What issues have been identified?

How important are they to you?

Signature of assessor: _____ Date: _____ Customer reference: _____

Do you need to take any action?

What do you hope will change as a result?

What is your level of need in this area?

How much assistance do you need with day-to-day tasks like cleaning and doing your laundry, also managing your money, paying bills and keeping the paperwork in order?

a) I manage my home and money independently ☐

b) With the right equipment I could manage my home and money independently ☐

c) I need **monthly** support to manage my home and money ☐

d) I need **weekly** support to manage my home and money ☐

e) I need **daily** support to manage my home and money ☐

Signature of assessor: Date: Customer reference:

5. Your accommodation and income

5.1 In general, are you happy with your accommodation?

Yes ☐ No ☐

5.2 Do you think your accommodation is affecting your health?

Yes ☐ No ☐

5.3 Would you like advice about financial allowances or benefits?

Yes ☐ No ☐

5.4 Are smoke detectors and carbon monoxide detectors in place?

Yes ☐ No ☐

5.5 Would you like a referral to the Fire Service?

Yes ☐ No ☐

COMMENTS

What issues have been identified?

Signature of assessor: Date: Customer reference:

Your accommodation and income, continued

How important are they to you?

Do you need to take any action?

What do you hope will change as a result?

Signature of assessor: Date: Customer reference:

6. Your safety

6.1 Do you feel safe inside your home?

Yes ☐ No ☐

6.2 Do you feel safe outside your home?

Yes ☐ No ☐

6.3 Do you ever feel threatened or harassed by anyone?

Yes ☐ No ☐

6.4 Do you ever feel discriminated against for any reason (e.g. your age, sex, race, religion)?

Yes ☐ No ☐

6.5 Is there anyone who would be able to help you in case of illness or an emergency?

Yes ☐ No ☐

6.6 Do you do things that put yourself at risk (e.g. leaving the cooker on, leaving doors unlocked, or wandering)?

Never ☐ Sometimes ☐ Yes, often ☐

If 'sometimes' *or* 'yes, often' *please specify:*

6.7 Do you do things that put other people at risk (e.g. getting angry or abusive)?

Never ☐ Sometimes ☐ Yes, often ☐

If 'sometimes' *or* 'yes, often' *please specify:*

Signature of assessor: Date: Customer reference:

COMMENTS

What issues have been identified?

How important are they to you?

Do you need to take any action?

What do you hope will change as a result?

Signature of assessor: Date: Customer reference:

If you have answered "Sometimes" or "Yes, often" to question 6.6 and/or 6.7 please state your level of need in this area

Safety during the day		Safety during the night	
a) I am able to keep safe without support	☐	a) I do not have any risks during the night and do not pose a risk to other people's safety	☐
b) There are risks to me at home, but these could be managed if I used special equipment or technology or if my home was adapted to meet my needs	☐	b) There are risks to me during the night but these could be managed if I used special equipment or technology or if my home was adapted to meet my needs	☐
c) I can be alone at home, but I need someone to check on me **weekly** and I would need support quickly if something went wrong	☐	c) To keep myself or others safe during the night I need someone to be available (e.g. someone sleeping at home) who can help or someone I can call on to help	☐
d) There are some risks to my safety and I need **daily** reminders, encouragement or support to manage these risks	☐	d) To keep myself or others safe during the night I need someone available **all the time**	☐
e) To keep myself or others safe during the day I sometimes need one-to-one support, so someone has to be available if needed to respond	☐	e) To keep myself or others safe during the night I need 2 people to be available **all the time**	☐
f) To keep myself or others safe during the day I cannot be left on my own and need one-to-one support	☐		
g) To keep myself or others safe during the day I cannot be left on my own and sometimes need 1 person to be there and a second person available if needed to respond	☐		
h) To keep myself or others safe during the day I cannot be left on my own and need 2 people to be with me at all times	☐		

Signature of assessor: Date: Customer reference:

7. Staying healthy

7.1 Do you take regular exercise?

Yes ☐ No ☐

7.2 Do you get out of breath during normal activities?

Yes ☐ No ☐

7.3 Do you smoke tobacco (e.g. cigarettes, cigars, pipes)?

Yes ☐ No ☐

7.4 Do you think you drink too much alcohol?

Yes ☐ No ☐

7.5 Has your blood pressure been checked recently?

Yes ☐ No ☐

7.6 Do you have any concerns about your weight?

Being overweight ☐ Weight loss ☐ No concerns ☐

7.7 Do you have any general concerns about your health?

Yes ☐ No ☐

If YES *please specify:*

Signature of assessor: _____ Date: _____ Customer reference: _____

COMMENTS

What issues have been identified?

How important are they to you?

Do you need to take any action?

What do you hope will change as a result?

Signature of assessor: Date: Customer reference:

8. Your mental health and wellbeing

8.1 In general, would you say your health is …

Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐

8.2 Do you feel lonely?

Never ☐ Sometimes ☐ Often ☐

8.3 Have you suffered any recent loss or bereavement?

Yes ☐ No ☐

8.4 Have you had any trouble sleeping in the last month?

Yes ☐ No ☐

8.7 Have you had much bodily pain in the last month?

Yes ☐ No ☐

If YES*, was it…*

Very mild ☐ Mild ☐ Moderate ☐ Severe ☐

8.6 During the last month, have you often been bothered by feeling down, depressed or hopeless?

Yes ☐ No ☐

8.7 During the last month, have you often been bothered by having little interest or pleasure in doing things?

Yes ☐ No ☐

8.8 Do you have any concerns about memory loss or forgetfulness?

Yes ☐ No ☐

COMMENTS

What issues have been identified?

How important are they to you?

Do you need to take any action?

What do you hope will change as a result?

Signature of assessor: Date: Customer reference:

What is your level of need in this area?

You might need help as a result of depression, severe anxiety or some other significant mental health problem.

a) I do not need any help to maintain my mental health and wellbeing ☐

b) I **sometimes** need support to maintain my mental health and wellbeing ☐

c) I need **weekly** support to maintain my mental health and wellbeing ☐

d) I need **daily** support to maintain my mental health and wellbeing ☐

9. Leisure, interests, hobbies and your community

9.1 Are you able to pursue interests and hobbies that are important to you?

Yes ☐ No ☐

9.2 Do you feel that you can participate in your community as much as you would like? (e.g. spending time with friends, going to local shops, the library, a luncheon club, your place of worship, or visiting other local organisations)

Yes ☐ No ☐

COMMENTS

What issues have been identified?
How important are they to you?
Do you need to take any action?

Signature of assessor: Date: Customer reference:

Your mental health and wellbeing, continued

What do you hope will change as a result?

What is your level of need in this area?

You might need help as a result of depression, severe anxiety or some other significant mental health problem.

a) I do not need any help to maintain my mental health and wellbeing ☐

b) I **sometimes** need support to maintain my mental health and wellbeing ☐

c) I need **weekly** support to maintain my mental health and wellbeing ☐

d) I need **daily** support to maintain my mental health and wellbeing ☐

Signature of assessor: Date: Customer reference:

10. Work and learning opportunities

10.1 Are you interested in pursuing opportunities for learning, for example, learning new skills, attending a college course or obtaining other qualifications?

Yes ☐ No ☐

10.2 If appropriate, would you like to pursue paid work or volunteering opportunities?

Yes ☐ No ☐

COMMENTS

What issues have been identified?

How important are they to you?

Signature of assessor: Date: Customer reference:

Work and learning opportunities, continued

Do you need to take any action?

What do you hope will change as a result?

What is your level of need in this area?

How much help do you need to be able to take part in work and learning opportunities?

a) I am happy with what I do in the daytime and do not need any help with this ☐

b) I have some opportunities to learn new things, work or keep busy. I would like to do more but would need some support to do this ☐

c) I would like to learn new things, work or keep busy; however I would need a lot of support to do this ☐

Signature of assessor: Date: Customer reference:

11. Caring and parenting

11.1 Do you need help to care for your children because of your disabilities? (If you have other caring responsibilities these are best supported by completing a carer's assessment)

Yes ☐ No ☐

COMMENTS

What issues have been identified?
How important are they to you?
Do you need to take any action?

Signature of assessor: Date: Customer reference:

What do you hope will change as a result?

What is your level of need in this area?

How much help do you need to care for your children because of your disabilities? (If you have other caring responsibilities, these are best supported by completing a carer's assessment)

a. I do not need help caring for children/this is not applicable to me ☐

b. I need some support caring for my children but not every day ☐

c. I need daily support for **up to 2 hours** to care for my children ☐

d. I need daily support for **between 2 and 6 hours** to care for my children ☐

e. I need daily support for **between 7 and 14 hours** to care for my children ☐

f. I need support **all the time** to care for my children ☐

Signature of assessor: Date: Customer reference:

12. Additional information

Are there any other issues that you would like to record? What other things are important to you in relation to your health and care?
How important are they to you?
Do you need to take any action?
What do you hope will change as a result?

Signature of assessor: Date: Customer reference:

Carer's comments

You can record your views here about the issues that have been identified.

Is there anything else about the person you care for that you think is important to mention?

As a result of your role as a carer are there any issues *for you*, which you would like to be addressed?

Do we need to take any action?

What do you hope will change as a result?

Signature of assessor: Date: Customer reference:

DOMAIN:	Communication	Looking after yourself	Managing your home and money	Safety		Mental health and wellbeing	Leisure, hobbies and community	Work and learning	Caring and parenting
				during the day	during the night				
1. How much of the help you need is currently provided by your family and friends?	None ☐ Up to 1/4 ☐ Up to 1/2 ☐ Up to 3/4 ☐ All ☐	None ☐ Up to 1/4 ☐ Up to 1/2 ☐ Up to 3/4 ☐ All ☐	None ☐ Up to 1/4 ☐ Up to 1/2 ☐ Up to 3/4 ☐ All ☐	None ☐ Up to 1/4 ☐ Up to 1/2 ☐ Up to 3/4 ☐ All ☐	None ☐ Up to 1/4 ☐ Up to 1/2 ☐ Up to 3/4 ☐ All ☐	None ☐ Up to 1/4 ☐ Up to 1/2 ☐ Up to 3/4 ☐ All ☐	None ☐ Up to 1/4 ☐ Up to 1/2 ☐ Up to 3/4 ☐ All ☐	None ☐ Up to 1/4 ☐ Up to 1/2 ☐ Up to 3/4 ☐ All ☐	None ☐ Up to 1/4 ☐ Up to 1/2 ☐ Up to 3/4 ☐ All ☐
2. If some of this help is provided by your family and friends …									
a) My family and friends are happy to keep giving me this much help	☐	☐	☐	☐	☐	☐	☐	☐	☐
b) My family and friends are happy to keep giving me this much help but would like **some** extra support	☐	☐	☐	☐	☐	☐	☐	☐	☐
c) My family and friends are happy to keep giving me this much help but would like **much more** support	☐	☐	☐	☐	☐	☐	☐	☐	☐

Signature of assessor: ____________ Date: ____________ Customer reference: ____________

Help from family and friends (continued)	Communication	Looking after yourself	Managing your home and money	Safety		Mental health and wellbeing	Leisure, hobbies and community	Work and Learning	Caring and parenting
				during the day	during the night				
d) My family and friends do not wish to keep giving me help – or they will be unable to provide help in the future	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. If some help is provided by your family and friends, how do you feel about this?									
a) I'm happy with the help my family and friends give me	☐	☐	☐	☐	☐	☐	☐	☐	☐
b) I would prefer to be less dependent on my family and friends	☐	☐	☐	☐	☐	☐	☐	☐	☐
c) I would prefer to be independent of help from my family and friends	☐	☐	☐	☐	☐	☐	☐	☐	☐

Signature of assessor: Date: Customer reference:

Summary of assessment

Record a summary of the assessment and the priorities that have been identified under *Issues*, *Importance*, *Actions* and *Desired Outcomes*. Start with the issues that are most important to the person being assessed.

Add any further information that is relevant to planning future care (such as details from further assessment information from *Supporting Instruments*).

Name of Assessor:	Signature of Assessor:	Date:

Agreed actions and referrals

What are the agreed actions and referrals? (Agreed outcomes linked to summary details should include the name of the person who has agreed to take action.)

Do you agree with the above assessment summary and plan of actions and referrals?

No ☐ Yes ☐ Verbal consent ☐

Signature: Date:

Arrangement of review of the above assessment outcomes

Review date:

For information about self-directed support or personal budgets email: selfdirectedsupport@leeds.gov.uk or contact **asist** on 0113 214 3599.
For general enquiries relating to Adult Social Care contact Customer Services on 0113 222 4401 or Textphone 0113 222 4410
If you would like this document in a different format, or would like help understanding it, let your social worker know or call one of the above numbers.

Signature of assessor: Date: Customer reference: