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| **Occupational Therapy Home Assessment Report** | **Surname:** **Given Name:** **DOB:****Sex:****Address:** |

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| **Date: Occupational Therapist:** |
| Relevant Medical History:Home Assessment Report |
| Mobility:  |
| Precautions: |
| Vision:  |
| Hearing: |
| **SOCIAL SITUATION:** Lives alone: Yes ☐ No☐ With whom:**Occupational Therapy Home Assessment Report** |
| Person(s) present at home visit: |
| Contact Person: Phone/Mobile: |
| **HOME ENVIRONMENT** Previous Home Visit**:** Yes  **☐** No ☐ Own ☐ Rented ☐ House ☐ Flat/ Unit ☐ Storey: Single ☐ Double ☐ |
| **Front Access:**Path:Porch:Step x:C:\Users\miboujaoude\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\UZI7FHBI\42_as_Interleaved_2_of_5_barcode[1].jpgRail x:Ramp:Comments: | **Back Access:**Path:Porch:Step x: Rail x:Ramp:Comments: | **Internal Access:**Split level:Step xRail x:Ramp:Comments: |
| **Bathroom:**☐ Shower ☐ Shower over bath ☐ Bath☐ Height \_\_\_\_\_\_\_\_\_\_\_\_mm☐ Screen ☐ RailsExiting Aids / equipment: | Bathroom transfer:Comments: |
| **Toilet:**☐ In bathroom/ ensuite ☐ Separate☐ Door inwards/outwards☐ Height \_\_\_\_\_\_\_\_\_\_\_\_mm ☐ RailsExiting Aids / equipment: | Toilet transfer:Comments: |
| **Bedroom:**☐ BED Height \_\_\_\_\_\_\_\_\_\_\_\_mm☐ S / D/ Q/ K☐ Bedside Light☐ Phone Exiting Aids / equipment: | Bedroom transfer:Comments: |
|  **Seating:**☐ Lounge / Armchair \_\_\_\_\_\_\_\_\_\_\_\_mm☐ Kitchen / Dining Chair \_\_\_\_\_\_\_\_\_\_mm☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mm | Chair transfer:Comments: |
| **Diagrams:** Additional diagrams attached ☐  |
| **Meals Preparation:**☐ Cooktop -Gas/electric ☐Oven -Gas/electric ☐Kettle -Gas/electric ☐Microwave Comments: |
| **Household Management:** |
| ☐Phone Use: ☐Turn on heater: ☐ Laundry☐ Garden careComments: | ☐ Rubbish care☐ Letter box☐ Smoke alarm |
| **Services Required:** |
| **Recommendations:** | **Actions required:** |
| **Summary:** |