OneVision
Connecting People with Purpose

SERVICE ASSESSMENT

NAME: _____ DATE ASSESSMENT COMPLETED: _____

I. MEDICAL ASSESSMENT:

A. Medical Conditions:

Yes	No	genito urinary
Yes	No	respiratory
Yes	No	cardiovascular
Yes	No	diabetes
Yes	No	gastrointestinal
Yes	No	endocrine
Yes	No	neurological/neuromuscular
Yes	No	cancer
Yes	No	immunological
Yes	No	skeletal
Yes	No	other _____

B. Does the person have a history of seizures?
Yes No

C. Frequency of seizures:
0. none this year
1. less than one a month
2. once a month
3. about once a week
4. several times a week
5. once a day or more

D. Does the person have a vagal nerve stimulator for seizures? Yes No

E. Is the person currently taking prescription medications? Yes No

F. Does the individual receive medication by injection? Yes No

G. Level of support the person needs to take prescription medications and treatments:
0. no medications
1. independent
2. supervision
3. assistance
4. total support

H. The person's typical level of mobility:
0. walks independently
1. walks independently with difficulty, no corrective devices
2. walks independently with a corrective device
3. walks only with assistance of another person
4. cannot walk

I. Does the person use a wheelchair? Yes No If Yes, please answer next question:

J. Indicate the response that best describes wheelchair mobility:

0. can use wheelchair independently
1. can use wheelchair independently with assistance transferring
2. requires assistance in transferring and moving
3. no mobility, must be transferred and moved.

K. Does the person need a mechanical lift for transferring? Yes No

L. Does the person use special adaptive equipment, including but not limited to: a walker, wheelchair, prosthetic device/s, head protective device, crutches, hearing aids, glasses, AFO's, braces, splints, gait belt, communication devices, eating device/s? Yes No
Please circle as applicable or indicate other:_____

_____

M. Indicate the response that best describes the number of health and medical appointments the person has a year:

0. 6 or less
1. 7 to 12
2. 13 or more

N. Does the person need OT evaluation and services? Yes No

O. Does the person need PT evaluation and services? Yes No

P. Does the person need Speech evaluation and services? Yes No

Q. Does the person require repairs to their wheelchair? Yes No

R. Does the person need support to complete physical therapy recommendations? Yes No

S. Do the person's needs require that the caregiver be trained in special health care procedures, including but not limited to: lifting and transferring, positioning, adaptive devices, hearing aids, seizure precautions, diabetic care, ostomy care? Yes No
Please circle as applicable or indicate other:_____

_____

T. Presently requires special diet planned by the dietitian? Yes No

V. Was hospitalized for a medical problem in the last year? Yes No

W. Does the person need to be turned at night in bed? Yes No

II. BEHAVIOR ASSESSMENT

0 - not this year; 1 - less than once a month; 2 - about one time a month; 3 - weekly;
4 - several times a week; 5 – one time a day or more; Circle the number that applies.

A. Indicate the frequency of each behavior over the last twelve months.

Has emotional outbursts:	0	1	2	3	4	5
Damages own or other property:	0	1	2	3	4	5
Physically assaults others:	0	1	2	3	4	5
Disrupts others:	0	1	2	3	4	5
Is verbally and gesturally abusive:	0	1	2	3	4	5
Is self injurious:	0	1	2	3	4	5
Teases and harasses peers:	0	1	2	3	4	5
Resistive to staff supervision:	0	1	2	3	4	5
Runs or wanders away:	0	1	2	3	4	5
Steals:	0	1	2	3	4	5
Eats inedible objects:	0	1	2	3	4	5
Displays sexually inappropriate behavior	0	1	2	3	4	5
Smears feces:	0	1	2	3	4	5
Demands extra attention from staff:	0	1	2	3	4	5

B. As a result of any challenging or interfering behavior(s), consider whether or not the following presently apply:

Yes No Does the person have a behavior program?

Yes No Are medications prescribed for behavior or mental health management?

Yes No The individual's environment must be carefully structured to avoid challenging or interfering behavior?

Yes No Staff must sometimes intervene with the use of restraint procedures.

Yes No Because of challenging or interfering behaviors, the person requires one-to-one supervision for many activities and tasks.

Yes No Because of challenging or interfering behaviors, the person requires visual supervision until completely calm, due to elopement or hurting others when upset.

Yes No Because of challenging or interfering behaviors, the person requires close supervision in community.

III. PERSONAL CARE ASSESSMENT

3 – Total support (dependent on others);
2 – Assistance (requires a lot of hand on help);
1 – Supervision (requires mainly verbal prompts);
0 – Independent (starts and finishes without any help or prompts at all).
Circle the number that applies. If a particular item is non-applicable, record a NA.

A. Indicate the best you can how independently the person typically performs each activity or task:

Pulling self up to standing:	3	2	1	0	NA
Toileting of bowels:	3	2	1	0	NA
Toileting bladder:	3	2	1	0	NA
Feminine hygiene:	3	2	1	0	NA
Taking a bath/shower:	3	2	1	0	NA
Brushing teeth/cleaning dentures:	3	2	1	0	NA
Brushing/combing hair:	3	2	1	0	NA
Selecting clothes for weather:	3	2	1	0	NA
Putting on clothes:	3	2	1	0	NA
Undressing self:	3	2	1	0	NA
Drinking from a cup/glass:	3	2	1	0	NA
Cutting food:	3	2	1	0	NA
Chewing and swallowing food:	3	2	1	0	NA
Feeding self:	3	2	1	0	NA
Shaving self:	3	2	1	0	NA
Making bed:	3	2	1	0	NA
Cleaning room:	3	2	1	0	NA
Doing laundry:	3	2	1	0	NA
Using telephone:	3	2	1	0	NA
Shopping for simple meal:	3	2	1	0	NA
Preparing foods that do not require cooking:	3	2	1	0	NA
Using stove or microwave:	3	2	1	0	NA
Crossing street in residential neighborhood:	3	2	1	0	NA
Using public transportation for a simple trip:	3	2	1	0	NA
Managing own money:	3	2	1	0	NA

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