My Initial Assessment

Guidance Notes

The My Initial Assessment (MIA) is split into sections;

Section 1 = this is generally completed by the CAD Hub over the phone with the customer to get an accurate picture on the customers personal details and current situation. This could however also be completed in a team by social care staff if for an existing customer.
Section 1a = this is specifically for customers who feel they would like a disability assessment and again would generally be completed at CAD Hub.
Section 2 = this is also completed at CAD Hub with input from Social Care staff to record the decisions made with how the case is to progress or not and why.
Section 3a = this is to be completed by social care staff when they complete a visit to assess the customer, or by the Hospital team is hospital. This would be blank if the referral was for disability referral only. You may also decide to complete a MACA instead of a section 3a.
Section 3b = this is for OT's to complete when they complete a visit to assess the customer for adaptations and equipment.
Section 3c = this is completed by the sensory service if the customer requires a Visual Impairment Assessment.
Section 3d = this is completed by the sensory service if the customer requires a Hearing Impairment Assessment.
Section 4 = can record carers details if the carer is present at the assessment, but should arrange to complete a Carers assessment with them if requested.

A MIA should therefore not be finalised until all relevant staff have completed their sections, but just save the changes. Some sections of the MIA will copy forward to a MACA and a CHC Social Care Report. You need to ensure you complete as much detail as possible and ensure it gives an accurate picture of the customers needs.

SECTION 1
Customer Information

The following statement should be read to the person being referred for services and their consent sought:

Personal data that you provide on this form is treated in confidence and complies with the requirements of the Data Protection Act (1988). The information will not be used for any other purpose than that advised to you. The Council may however contact other organisations to verify the information on this form. By agreeing to this statement, as a service user or representative on behalf of the service user, you are explicitly providing consent that the personal data and sensitive personal data provided can be used for purposes other than this form. The information that you give to us will be used to assess and provide suitable Health and Social Care Services.

*If someone is hearing impaired then you may wish to omit reading out this statement and will be addressed at a later stage.

Self Referral	
Consent Given?	Yes ☐ No ☐
3rd Party Referrer	
Is the customer aware of the referral?	Yes ☐ No ☐
Person Requiring Assessment	
Protocol Number	
NHS Number	
National Insurance Number	
Title	Surname
First Name(s)	
Date of Birth:	**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Living with Partner ☐ Separated ☐ Unknown ☐ Prefer Not to Say
Gender: Male ☐ Female ☐	

Permanent / Other Residence	
Post Code	
Current Address (if different to above)	
Post Code	
Ethnicity	First Language

Is an interpreter required?

Yes ☐ No ☐
If yes, what language is required?

Religion or Belief

Sexual Orientation	**Are you pregnant?**
☐ Heterosexual	☐ Yes
☐ Bisexual	☐ No
☐ Lesbian/Gay Woman/Gay Man	☐ Prefer Not to Say
☐ Prefer Not to Say	☐ Not Known

Have you ever had any gender reassignment surgery?

Yes ☐ No ☐ Prefer Not to Say ☐

Domestic Arrangements	
Do you live alone?	Yes ☐ No ☐
Type of Accommodation	
Do you have a key safe?	Yes ☐ No ☐

Type of Tenure:

☐ Bed and Breakfast
☐ Emergency accommodation
☐ Lives rent free
☐ Not applicable
☐ Owns property

☐ Private Rented ☐ Social Rented ☐ Other - please supply details:	
If not owner occupier, please provide contact details for Landlord or Housing Association:	
Name:	
Address:	
Post code:	
Contact No:	
Email address:	

Employment	
Are you in paid employment? If Yes: Position: Employment Type: ☐ Employed (Paid) ☐ Self-Employed (Paid) ☐ Self-Employed (Unpaid) ☐ Voluntary (Paid) ☐ Voluntary (Unpaid) ☐ Unemployed ☐ Retired Weekly hours:	Yes ☐ No ☐

Customer Contact Details (please tick the best number to be contacted on)	
☐ Home Phone Number	
☐ Work Phone Number (if employed only)	
☐ Mobile Phone Number	
☐ Other (Relative/Friend etc)	
E-mail address	

Carer Details	
Do you have someone that supports you and helps you with your day to day life that you consider to be your Carer?	Yes ☐ No ☐*

If customer has a carer complete below:	
Is that person your next of kin?	Yes ☐ No ☐
Do they live at the same address?	Yes ☐ No ☐
Are you aware that carers are entitled to an assessment of their needs?	Yes ☐ No ☐
Do you think that your Carer would like a Carers Assessment?	Yes ☐ No ☐
Carers first name	
Carers surname	
Carers Address	
Carers contact details	
If you think the carer would not like an assessment, would they be happy for us to pass on their details to the Carers Service?	Yes ☐ No ☐
Information about the Carers Service is available on our website at www.Bury.Gov.Uk/Adults. Would you like us to send some information about the Carers Service?	☐No ☐Yes by e-mail (please provide e-mail address below) ☐Yes by letter (please provide address below)
Next of Kin	
Do you have a Next of Kin?	Yes ☐ No ☐
Name	
Relationship	
Contact Number	
Do they live at the same address as you?	Yes ☐ No ☐
If not, please state address:	

Emergency Contact	
If not Next of Kin – please give details:	
Name	
Address	
Contact Number	
Relationship	

GP Details	
Name of GP:	
Address of GP:	Telephone No. of GP:

Other Professionals (including Health)	
Do you have any professionals involved in your care at the moment? :	Name and contact details of Professional:
☐No Professionals involved	
☐Social Worker	
☐District Nurse	
☐CPN	
☐Physiotherapist	
☐Occupational Therapist	
☐ Rehab Officer Hearing Impairment	
☐ Impairment/Rehab Officer Visual Impairment/Assessment worker Visual Impairment	
☐Consultant	

☐ Personal Assistant (PA)	
☐ Hospice /Macmillan/ Palliative Care Services	
☐ Falls Prevention Service	
☐ Other e.g. support groups- please provide details	

How do you feel we can help you?

Existing Support Networks	
Do you currently receive any support from the following:	
☐ Mobile Warden Service (Support to Live at Home)	
☐ Employed Cleaner	
☐ Carelink	
☐ Home Care	Name of Agency:
	How many visits do you have per day?
	How many carers come on a visit?

☐Day Care	Where do you attend Day Care?
	How many times per week do you attend?
☐Meals-on-Wheels	How many days per week do you receive them?
☐ Planned Regular Short Term Breaks	Do you have planned regular short-term breaks?
	Who provides the breaks?
	Date of your last stay?
☐Friends & Family	Who supports you? ☐Parent ☐Son ☐Daughter ☐Brother ☐Sister ☐Aunt ☐Uncle ☐Grandparent ☐Other – please supply details:
	What support do they provide?
☐Other	please supply details:
Are you in receipt of a Personal Budget?	Yes ☐ No ☐ Don't Know ☐
Are you in receipt of any benefits	Yes ☐ No ☐ Don't Know ☐ If Yes, provide details
Are you aged between 17-25 and receiving support from Children's Services? (transitions case)	Yes ☐ No ☐

If Yes please give details of what support and any professionals involved with you.	
Do you have fire/ smoke alarms fitted?	Yes ☐ No ☐
If ticked 'no', does the customer want to be referred to the GM Fire Service? Yes/No	
If yes, Would you be able to hear your smoke alarm at night (without your hearing aid if the customer wears one)?	Yes ☐ No ☐
Have you had an Affordable Warmth Assessment?	Yes ☐ No ☐

Communication	
Do you have any difficulties with your: 1. Hearing	Yes ☐ No ☐ If **Yes** go to Hearing section below but if the customer is struggling to hear the conversation go the end and send to Triage.
2. Sight	Yes ☐ No ☐ If **Yes** go to Sight section below
3. Speech (disability/health related)	Yes ☐ No ☐ If **Yes** go to Speech section below
4. Confused/ Dementia	Yes ☐ No ☐ If **Yes** go to Confused/ Dementia section below
5. Literacy (Reading or writing)	Yes ☐ No ☐ If **Yes** go to Literacy section below
Do you have a dual sensory loss?	Yes ☐ No ☐ If **Yes** go to Other section below
Hearing	
Are you registered hearing impaired?	Yes ☐ No ☐
Are you registered deaf?	Yes ☐ No ☐
Do you have a hearing aid?	Yes ☐ No ☐
Do you wear your hearing-aid?	Yes ☐ No ☐
Does your hearing-aid work?	Yes ☐ No ☐
Have you had a hearing test in the last 18 months?	Yes ☐ No ☐
Can you hear your television?	Yes ☐ No ☐
Can you hear your doorbell or knocking on your front door?	Yes ☐ No ☐

Can you hear your telephone ring?	Yes ☐ No ☐
Can you hear on the telephone?	Yes ☐ No ☐
Can you hear your alarm clock?	Yes ☐ No ☐
Do you have difficulty hearing in a group social setting such as a crowd?	Yes ☐ No ☐

What is your preferred format for any future communication?

☐ Text
☐ Email
☐ Letter
☐ Face to face
☐ Other- please give details:

Comments on any of the above…

Give details of any specific communication issues for the customer, eg any use of communication aids, and/or support required in particular environments

Sight

Are you registered visually impaired?	Yes ☐ No ☐
Are you registered blind?	Yes ☐ No ☐
Have you had a sight test within the last 12 months?	Yes ☐ No ☐
Have you visited the Low Vision Aid Clinic in the last 12 months?	Yes ☐ No ☐

What is your preferred format for any written communication?

☐ Large print
☐ Audio CD
☐ Braille
☐ Other - please give details:

Comments about your sight

Give details of specific issues relating to sight for this customer

Speech

Please describe your speech impairment and how this affects you:

Highlight the individual issues relating to this customers speech and how this affects their daily living

Do you use any equipment to support how you communicate? **If yes, please give detail of the specific equipment used and how this assists the customer**
How would you like us to contact you in the future?
Confused / Dementia
How does this affect you? **Give specific examples of how the customers daily life is affected by any confusion they may experience within and outside of the everyday living environments**
Literacy

Do you have any reading or writing difficulties?	Yes ☐ No ☐ If yes, please give details
Do you have any equipment to help you with reading/writing?	Yes ☐ No ☐ If yes, please give details

Other
What is your communication difficulty and how does this affect you? **Summarise what the issues are and add any further comments relevant to this area of need**

General Health	
Have you got any health problems or needs?	Yes ☐ No ☐
If YES please supply details: **Summarise what the issues are and add any further comments relevant to this area of need**	

Do you have a diagnosis of a medical condition?	Yes ☐ No ☐
What is your diagnosis? (Insert glossary of terms/ medical dictionary)	
When were you diagnosed?	
Who were you diagnosed by?	
Are you currently taking any medication?	Yes ☐ No ☐
Are you having any difficulties taking your medication? **If yes, give details of the specific difficulty being experienced by the customer and how this affects them**	
Have you been discharged from hospital in the last 6 months?	Yes ☐ No ☐
What was the reason for your hospital admission? **Describe the detail and the circumstances around the admission**	
Which hospital did you attend? ☐ Fairfield General Hospital ☐ Floyd Unit ☐ North Manchester General Hospital ☐ Manchester Royal Infirmary ☐ Salford Royal Hospital (Hope) ☐ Oldham Royal Infirmary ☐ Rochdale Infirmary ☐ Royal Bolton Hospital ☐ Royal Blackburn Hospital ☐ St Mary's Hospital ☐ The Christie Hospital ☐ Wythenshawe Hospital	

☐ Withington Community Hospital ☐ Other – please provide details	
FALLS	
Have you experienced falls in the last 6 months?	Yes ☐ No ☐
If YES, how many falls have you experienced?	
Please supply details of your falls: **Is there a particular trigger or pattern to the falls? E.g. is it to do with sight impairment, physical disability/illness, environmental hazards, balance issues etc**	

Please be advised that some assessed services are means tested. This may mean that you have to contribute in part or in full to the cost of services that you may need following your assessment.

Do you wish to continue with this referral? Yes ☐ No ☐

SECTION 1A Initial Disability/ Sensory Referral

Property Details

What style of property do you live in?

- ☐ Caravan or other mobile or temporary structure
- ☐ Care Home (with nursing)
- ☐ Care Home (without nursing)
- ☐ Flat, Maisonette or apartment
- ☐ Terraced House
- ☐ Detached House or Bungalow
- ☐ Semi-Detached House or Bungalow
- ☐ Sheltered Housing
- ☐ Other- please supply details:

How many years have you lived in this property?	
How many bedrooms does the property have?	
Does your property have the following rooms: ☐ Kitchen ☐ Dining-room ☐ Kitchen/Dining-room ☐ Lounge ☐ Conservatory ☐ Den/Playroom ☐ Study ☐ Bedroom ☐ Other- please supply details:	How many ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
How many adults live in the house?	
How many children live in the house and what are their ages?	No of children Ages ☐☐☐☐☐

OUTDOOR MOBILITY

Can you get from the pavement to the door of your property independently?	Yes ☐ No ☐
Is there adequate outdoor lighting at your main door?	Yes ☐ No ☐
Do you use any equipment/adaptations to help you?	
☐ No	If you don't use any equipment to help you, how do you manage?

☐ Yes	What do you use? ☐ Walking Stick ☐ White Walking Stick with additional colour indicator ☐ Crutch ☐ Walker ☐ Self-propelling wheelchair ☐ Step-lift ☐ Attendant propelled wheelchair ☐ Ramp ☐ Grab-rails ☐ Scooter * ☐ Powered wheelchair* ☐ Long Cane ☐ Guide Dog ☐ Previous mobility training (for Visual Impairment) ☐ Other– please supply details:
*Has this been assessed and recommended by a medical professional? Yes ☐ No ☐	
Comments about outdoor mobility **Give as much detail as possible to highlight the issues for the customer when mobilising outdoors. E.g. is support required to enable the customer to mobilise safely outdoors? If so, what are the factors and risks involved?**	
GETTING ABOUT WITHIN YOUR OWN HOME	
Can you hear the doorbell or if someone is knocking at your door?	Yes ☐ No ☐
Do you have any equipment to help you?	
☐ No	If you don't have any equipment to help you answer the door, how do you manage?
☐ Yes	What do you use? ☐ Key safe ☐ Door intercom ☐ Flashing door bell

	☐ Vibrating Pager ☐ Other -please supply details
Do you use any equipment/adaptations to help you mobilise indoors?	
☐ No	If you don't use any equipment to help you, how do you manage?
☐ Yes	What do you use? ☐ Walking Stick ☐ White Walking Stick with additional colour indicator ☐ Crutch ☐ Furniture Walk ☐ Walker ☐ Self-propelling wheelchair ☐ Step-lift ☐ Attendant propelled wheelchair ☐ Ramp ☐ Grab-rails ☐ Scooter * ☐ Powered wheelchair* ☐ Long Cane ☐ Guide Dog ☐ Previous mobility training (for Visual Impairment) ☐ Other– please supply details:
*Has this been assessed and recommended by a medical professional? Yes ☐ No ☐	
Comments about indoor mobility **Give as much detail as possible to highlight the issues for the customer to mobilise safely indoors? Are there issues with transfers etc? If so, has an Occupational Therapy Assessment been undertaken? If so, highlight the factors and risks involved.**	
STAIRS	
Do you have any stairs in your property?	Yes ☐ No ☐

Do you have any equipment/adaptations or additional lighting to help you with the stairs?	
No ☐	If you don't have any equipment or adaptations, how do you manage the stairs?
Yes ☐	What equipment/ adaptations do you use? ☐ banister/ hand rail on one side ☐ Banister/ hand rail on two sides ☐ Stair lift ☐ Through floor-lift ☐ Additional lighting ☐ Other– please supply details:
Comments about using stairs **Does the customer have a specific way of undertaking this activity. Are there any risks involved in undertaking this activity? Is additional support required to ensure safety?**	
Thinking about your living room / lounge…	
Can you get on and off your chair/armchair/settee independently?	Yes ☐ No ☐
Do you have any equipment or need support to help you get in and out of the chair?	
No ☐	If you have no equipment/support, how do you manage to get in and out of your chair?
Yes ☐	What equipment/ Support do you have? ☐ Chair raisers ☐ Riser-recliner chair ☐ Hoist

	☐ Help from Carer ☐ Other – please supply details:
Additional comments: **Describe how any additional support or equipment assists the customer to undertake this activity.**	
Thinking about your daily living tasks (Sensory impairment)…	
Can you manage to do your shopping? Yes ☐ No ☐ If No, please explain how you manage **Describe the current situation**	
Can you manage to do your laundry/ironing/housework? Yes ☐ No ☐ If No, please explain how you manage **Describe the current situation**	
Are you having accidents e.g. burns when doing any of the above? Yes ☐ No ☐	
Thinking about your kitchen…	
Can you prepare a hot drink?	Yes ☐ No ☐
If yes, do you have any difficulty preparing a hot drink?	Yes ☐ No ☐
If yes- Please explain the nature of your difficulty? (for example frequent burns, how often does this happen?)	
Do you need any equipment or support to help you make a hot drink?	
No ☐	If you have no equipment/support, how do you manage to make a hot drink?
Yes ☐	What equipment/ Support do you use? ☐ Carer ☐ Family member ☐ Trolley ☐ Small kitchen aid- e.g. kettle tipper/

	liquid level indicator-please give details: ☐Other- please give details:
Can you prepare a light meal?	Yes ☐ No ☐
If yes, do you have any difficulty preparing a light meal?	Yes ☐ No ☐
If yes, what is the nature of your difficulty? **Describe in detail the difficulty the customer experiences**	
Do you need any equipment or support to help you make a light meal?	
No ☐	If no equipment/support is required, how do you manage to make a light meal?
Yes ☐	What equipment/ Support do you have? ☐Community meals/ Meals on Wheels ☐Microwave meals / ready-made meals ☐Carer ☐Family Member ☐Trolley ☐Small kitchen-aid - please give details ☐Other – please supply details:
Additional comments (such as difficulty in seeing dials on cooker/ microwave/ lighting a gas cooker/ reading instruction on ready meals) **Describe in detail the current situation and issues involved for the customer**	
Thinking about your bedroom…	

Can you access your bedroom independently?	Yes ☐ No ☐
Can you get in and out of bed independently?	Yes ☐ No ☐
Do you have any equipment or support to help you get in and out of bed?	
No ☐	If no equipment /support how do you manage to get in and out of bed?
Yes ☐	What equipment/ Support do you use? ☐Bed lever ☐Bed rail ☐Pillow rest ☐Hospital/Specialist Powered Bed ☐Hoist ☐Help from Carer ☐Mattress variator ☐Other – please supply details:
Do you have any concerns about getting dressed or undressed?	Yes ☐ No ☐
If Yes – please supply details	
Do you have equipment or support to help you get dressed?	
No ☐	If you do not use equipment/support, how do you manage to get dressed?
Yes ☐	What equipment/ Support do you use? ☐Carer ☐Minor equipment such as to help with buttons, tights etc - please give details: ☐Other- Please give details:
Additional comments:	
Thinking about your bathroom…….	

Can you access your bathroom independently?	Yes ☐ No ☐
What type of bath do you have? ☐Do not have a bath ☐Straight bath ☐Corner bath ☐Other -please supply details:	
Do you have any equipment or support to help you with bathing?	
No ☐	If you do not use equipment/support, how do you manage bathing?
Yes ☐	What equipment/ Support do you use? ☐Grab rails ☐Bath lift ☐Bath hoist ☐Bath board ☐Bath seat ☐Bath mat ☐Bath step ☐Help from Carer ☐Other -please supply details:
What type of shower do you have? ☐Do not have shower ☐Do not have shower but have shower attachment fitted to taps ☐Shower over bath ☐Separate shower cubicle ☐Wet room / level access shower ☐Other – please supply details:	
Do you have any equipment or support to help you with showering? **Describe the specific support required**	
No ☐	If you do not use any equipment/support how do you manage showering?

Yes ☐	What equipment/ Support do you use? ☐Help from Carer ☐Grab rails ☐Shower seat/stool ☐Small aid such as long handled sponge, toe cleaner etc- please give details: ☐Other – please supply details:
Can you access (get on and off) the toilet/commode independently?	Yes ☐ No ☐
Do you have any equipment or support to help you?	
No ☐	If you do not use any equipment / support how do you manage getting on and off the toilet?
Yes ☐	What equipment/ Support do you use? ☐Grab rails ☐Toilet frame ☐Raised toilet seat ☐Self cleansing toilet (closomat – toilet that cleans and dries you) ☐Hoist ☐Help from Carer ☐Other – please give details:
Do you have any concerns about your personal hygiene?	Yes ☐ No ☐
If Yes – please give details:	
Do you use any equipment or support to help you with your personal hygiene? ☐No equipment/support ☐Carers ☐Equipment – please give details: ☐Other – please give details:	

Do you have any concerns about your continence?	Yes ☐ No ☐
If Yes – please give details: **Highlight the specific difficulties and support required in this area**	
Do you use any equipment or support to help you with your continence? ☐No equipment/support ☐Pads ☐Catheter ☐Commode ☐Urine Bottle ☐Sheath ☐Stoma Bag ☐Carers ☐Medication – please give details: ☐Other – please give details:	
Have you had an assessment for continence difficulties?	Yes ☐ No ☐
If Yes - please give details:	
Additional Comments:	
Please be advised that some assessed services are means tested. This may mean that you have to contribute in part or in full to the cost of services that you may need following your assessment. Is the customer aware that they may be charged for services? Yes ☐ No ☐ Do you wish to continue with this referral? Yes ☐ No ☐	

SECTION 2 TRIAGE ASSESSMENT & OUTCOMES

Triage Officer Actions

	Date	Time	Method (Telephone/ E-mail/ text/ Other)	Contact Made Y/N	Worker name	Comments/ Action Required
Attempt 1						
Attempt 2						
Attempt 3						

Recommendations/ Rational of Decisions from Triage Officer:

In your opinion, how quickly do you feel a response is needed?

☐ Within 1 day ☐ Within 1 week	Why do you feel this is so urgent?

Assessment Cancelled

☐ No contact letter sent (Ensure you send a no contact letter)	Date letter sent:
☐ NFA Refusal (Ensure you send a refusal letter)	Date letter sent:

☐ NFA Information sent

☐ NFA Advice Given

☐ NFA Referral to Universal

☐ NFA Inappropriate
☐ NFA Deceased
☐ NFA Moved out of area
☐ NFA Referral to external organisation
☐ NFA Other- please state

Further Assessment

☐ cause for concern/ repeated NFA referrals – requires follow up
☐ Urgent Duty Visit Required
☐ Safeguarding alert raised
☐ Referral made to external agencies:

Organisation/ Service	*Date*	*Contact Details*

☐ URGENT referral to team:

☐ ART
☐ VAT
☐ LDT
☐ MENTAL HEALTH
☐ REABLEMENT
☐ HOSPITAL TEAM
☐ CRISIS RESPONSE

Date:

Purpose:

☐ Re-assessment
☐ Review
☐ MIA Section 3 completed
☐ Carers Assessment
☐ Human Rights assessment
☐ Disability Assessment
☐ VI Rehab Assessment
☐ VI Initial Assessment
☐ HI Rehab Assessment
☐ Connect and Direct Appointment
☐ Other;

☐ Referral to team:

☐ ART
☐ VAT
☐ LDT
☐ MENTAL HEALTH
☐ REABLEMENT
☐ HOSPITAL TEAM
☐ CRISIS RESPONSE

Date:

Purpose:

☐ Re-assessment
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☐ VI Rehab Assessment
☐ VI Initial Assessment
☐ HI Rehab Assessment
☐ Connect and Direct Appointment
☐ Other;

HOSPITAL REFERRAL INFORMATION Details of Hospital Admission (to be completed by Hospital Admin only)	
Ward Name	
Date of Admission	
Estimated date of discharge	
Name of Consultant	
Reason for Admission:	
Diagnosis/Prognosis/Other health problems	
Has the person had frequent hospital admissions over the past 12 months? Yes ☐ No ☐	
Has the person been screened for CHC?	Yes ☐ No ☐ Pull through from hosp section of contact form
If Yes, has a full CHC assessment been completed?	Yes ☐ No ☐ Pull through from hosp section of contact form
Summary of Customer's Needs	
Serious head injury has occurred	Yes ☐ No ☐
Alcohol or drug abuse presents as a serious problem	Yes ☐ No ☐
Person is terminally ill	Yes ☐ No ☐
Person is distressed about going home or anxious about being in hospital	Yes ☐ No ☐
Person is already in receipt of services from Adult Care	Yes ☐ No ☐
Person is resident in a care home	Yes ☐ No ☐
Person appears non-alert/confused/disorientated/lacking capacity	Yes ☐ No ☐
Person has unexplained bruising/injuries or domestic violence has occurred	Yes ☐ No ☐
Person has difficulty with any of the following tasks/activities:	

- Communicating	Yes ☐ No ☐
- Mobilising	Yes ☐ No ☐
- Eating/drinking	Yes ☐ No ☐
- Toileting	Yes ☐ No ☐
- Personal care	Yes ☐ No ☐
Person is homeless	Yes ☐ No ☐
Name of person completing S2 form	
Designation / Role	
Date of notification	
Name of Hospital	
Name of admin worker who inputted S2 form	

SECTION 3A Social Care Visit
Customer name:
PROTOCOL Number:
Check that we have correct personal details for the customer and amend as required.
Name of Worker:
Date of Screening:
I have had the assessment process explained to me and consent to this assessment. I am aware that other professionals from other agencies such as my GP, District Nurse and Health Providers may share this information. ☐ Yes ☐ No
Signed: (Customer / Assigned Person)*
Date:
*if not signed, please state reason why:
Is there anyone you would not consent to us sharing this information with? ☐ Yes ☐ No
If yes, who?

To start the assessment first go through and verify info already gathered on Section 1 & 2		
Physical and Mental Wellbeing		
Please tick any boxes that apply to the customer and comment;		**Comments / Risk Factors**
Depression		**Give details of any specific difficulties the customer experiences in relation to any of the areas highlighted.** **Note that information inserted into this section will be pulled through into section 1 of the MACA**
Dementia		
Confused/Disorientated		
Cognitive Problems/Memory loss		
Reactions to loss/bereavement		
Emotional Difficulties		

Other		

Please summarise physical health needs from information collated in section one:
Pull through text inserted here to section 1 of the MACA.
Give detail of any specific physical health needs and how these needs affect the customer in their activities of daily life. Identify any support required to assist the customer in this area

Does the customer lack capacity to make decisions over any aspect of their care, finances, treatment or safety? ☐ Yes ☐ No ☐ Don't know

If YES, please comment:
Insert the detail of the specific decision relating to the customers lack of capacity

Does anybody have Enduring/Lasting Power of Attorney of your property and finances?
☐ Yes ☐ No ☐ Don't know
If YES**,** please supply details below:

Does somebody else have Lasting Power of Attorney in relation to your health and welfare?

☐ Yes ☐ No ☐ Don't know

If YES**,** please supply details below: Who has the power? Relationship to cared for:	Name: Address: Contact Details:

Is this customer approaching end of life? If yes then check for involvement with end of life services.	☐ Yes ☐ No

BEHAVIOUR

Are there any behavioural needs that may cause a risk to self or others? If YES, please explain and indicate level of potential risk and to whom:

Give details about current concerns around risk and behaviour to self or others and also any relevant historical information

LOOKING AFTER YOURSELF DURING THE DAY

Please tick any boxes that the customer needs assistance with and comment;		**Comments / Risk Factors**
Physical Appearance		**Highlight the specifics of the needs identified opposite and the assistance required to meet these needs. Include whether the customer requires physical, verbal, emotional or psychological support with these issues, for example, verbal prompts to assist with dressing, or physical assistance required with bathing to ensure standard of cleanliness and hygiene is maintained.**
Washing		
Bathing		
Toileting		
Dressing		
Oral Health		
Footcare		

Tissue Viability		
Mobility		
Continence		
Pain Management		
Any equipment and adaptations in the home		

ASSISTANCE DURING THE NIGHT

Please tell us about any assistance you need during the night?
Insert the reasons the support is required and what is involved. For example, the customer may wander at night and need constant monitoring, or the customer may need assistance with toileting during the night

EATING AND DRINKING

Please tick any boxes that apply to the customer and comment;		**Comments / Risks**
Need assistance to prepare food and drinks		**Provide the detail of the need and what support is required to meet this**
Need assistance with cooking		
Need assistance to eat my meal eg cutting up of food/ prompting to eat		
Have community meals		

Other issues with eating and drinking		

PRACTICAL ASPECTS OF DAILY LIVING

Please tick any boxes that apply to the customer and comment;		**Comments/Risks**
Need assistance managing my money, budgeting and paying bills		**Provide the detail of the need and what support is required to meet this**
Need assistance with shopping		
Need assistance to do laundry and changing the bed		
Need assistance to clean my home		
Need assistance to deal with letters and form filling		
Need assistance with contacting appropriate people to carry out maintenance to my home and garden.		

COMMUNITY INVOLVEMENT

Do you live alone?	☐ Yes ☐ No

How do you manage getting out and about to engage in social and community activities e.g day clubs, church, cinema, friends etc?
List the activities currently being undertaken and the support required to enable this to happen

MAINTAINING RELATIONSHIPS WITH FRIENDS AND FAMILY

Tell us about what assistance and support you need to keep in touch with friends, family and to socialise with other people.

LEISURE, LEARNING AND WORK	
Are you employed?	☐ Yes ☐ No
What are your leisure activities and hobbies? What help do you need to access these?	
COMMUNICATION	
Do you have any communication difficulties?	Yes ☐ No ☐
If Yes, is your communication difficulty to do with: 1. Hearing 2. Sight 3. Speech (disability/health related) 4. Other 5. Deaf/Blind (dual sensory)	 Yes ☐ No ☐ If **Yes** go to Hearing section below Yes ☐ No ☐ If **Yes** go to Sight section below Yes ☐ No ☐ If **Yes** go to Speech section below Yes ☐ No ☐ If **Yes** go to Other section below Yes ☐ No If **Yes** complete hearing and sight section below
Hearing	
Are you registered hearing impaired?	Yes ☐ No ☐
Are you registered deaf?	Yes ☐ No ☐
Do you have a hearing aid?	Yes ☐ No ☐
Do you wear your hearing-aid?	Yes ☐ No ☐
Does your hearing-aid work?	Yes ☐ No ☐
What is your preferred format for any future communication?	

☐Text
☐Email
☐Letter
☐Face to face
☐Other- please give details:

Comments about your hearing difficulties:

Sight

Are you registered visually impaired?

Are you registered blind?

What is your preferred format for any written communication?

☐Large print
☐Audio CD
☐Other - please give details:

Comments about your visual difficulties:

Speech

Please describe your speech impairment and how this affects you:

How would you like us to contact you in the future?

Other

What is your communication difficulty and how does this affect you?

First Language:		
Is an interpreter required?		Yes ☐ No ☐
MANAGING RISK AND STAYING SAFE		
Please tick any issues that are applicable for the customer and comment.		**Comments**
Are there any needs that may cause a risk to self?		**Provide specific details of all aspects and concerns relating to actual and potential risks for the customer and others**
Are there any needs that may cause a risk from others?		
Is the customer at risk of significant harm because of possible abuse or neglect? If yes, consider Safeguarding alert.		
Has the customer been subject to any previous risk of significant harm because of abuse or neglect?		
Is the customer at risk due to substance misuse?		
Is the customer at risk due to self harm?		
Are there any sensory difficulties that may impact upon safety?		
Has the customer had a Carelink/ Telecare assessment? ☐ Yes ☐ No		
If yes, what equipment do they have?		
Does the customer have a fire/ smoke alarm fitted?		☐ Yes ☐ No
Do you consider this person to be at risk from fire due to any of the following circumstances; Physical health, Mobility difficulties, Memory impairment, Mental health, Prescribed medication, Sensory impairment, or Learning disability Yes ☐ No ☐ *If Yes refer to GM Fire Service.*		
Bury Adult Social Care is helping people become more involved in the way they have their social care needs delivered - this is known as Self Directed Support (SDS) and gives the person much more choice, flexibility and control of their lives. Following further assessment you will know how much money is available to help you. We will then support you to create a plan and agree your personal budget. You can then be in control of how you spend the money on the support you need, rather than having to choose existing traditional services.		

Having explained this to you would you like have a further discussion and assessment with one of our staff to see if this is for you? / Would you like to complete the process so you know your indicative budget?

Decline ☐ Accept ☐

Has the CHC checklist been completed?

☐ Yes ☐ No

Customer Perspective (Needs and issues in the customers own words)

Provide specific details of all aspects and concerns relating to actual and potential risks for the customer and others

FACS Eligibility Screening Tool	
Threshold set at CRITICAL	
They need help to carry out all aspects of personal care or domestic tasks	
They need help to be involved in work, education, learning and in the community that is vital to their independence	
They need help to keep relationships vital to their independence	
They need help to keep family and other social roles and responsibilities vital to their independence	
They have experienced serious abuse or neglect	
They feel they have no choice and control over the world around them	
They have significant health problems	
Their life is at risk	
Threshold set at SUBSTANTIAL	
They need help to carry out most personal care or domestic tasks	

They need help to be involved in many aspects of work, education, learning and in the community	
They need help to maintain most of their important relationships	
They need help to keep most of their family and other social roles and responsibilities	
They at risk of being abused or neglected	
They feel they have only partial choice and control over the world around them	
Threshold set at MODERATE	
They need help to carry out several personal care or domestic tasks	
They need help to be involved in several aspects of work, education, learning or in the community	
They need help to maintain several important relationships	
They need help to keep several family and other social roles and responsibilities.	
Threshold set at LOW	
They need help to carry out one or two personal care or domestic tasks	
They need help to be involved in one or two aspects of work, education, learning or in the community	
They need help to maintain important relationships	

In order to be eligible for social care services, an individual must meet at least one of the criteria in either the CRITICAL or SUBSTANTIAL domains ONLY.	
Does the customer meet Fair Access to Care Services (FACS)?	☐ Yes ☐ No
Following an assessment of my needs, it has been explained to me that any services being offered to me may be subject to an assessment of my ability to contribute towards the cost of this service and that I may be visited by a Financial Assessment Officer. Tick ☐ Yes ☐ No please state if this has been explained to anyone else with the customer	
Signed (Customer / Assigned Person) *	
*if not signed, please state reason why:	
Date:	
Has the customer been given a copy of the 'What do you think?' booklet? ☐ Yes ☐ No	

How satisfied have you been with the assessment process so far?

☐ Very satisfied
☐ Satisfied
☐ Dissatisfied
☐ Very Dissatisfied

Comments about the assessment process so far:

How clear are you about what will happen next?

☐ Very clear
☐ Clear
☐ Unclear
☐ Very Unclear

Comments about what will happen next

Insert agreed actions, who is responsible and the timescales involved in actions being completed

ACTIONS

Actions taken by Assessment Officer following completion of My Initial Assessment:

List the planned interventions following the assessment and provide details of who will complete each action and the timescales involved.

Outstanding actions to follow up:

List any further actions required in addition to those listed above

Name of assessing officer:

CUSTOMER OUTCOMES (to be completed by ACS staff)

- ☐ Assessment cancelled
- ☐ Cancelled/Client Died
- ☐ Cancelled/Client Moved
- ☐ Further Assessment
- ☐ New services offered but declined
- ☐ NFA- No (new) services offered or intended to be provided
- ☐ No new services offered or intended
- ☐ Some new services intended but not yet started
- ☐ Some or all services already started (including those started and finished)
- ☐ Other Sequel to Assessment

Client Category;

- ☐ Learning Disability - Autism Spectrum
- ☐ Learning Disability - Downs Syndrome
- ☐ Learning Disability - Mild
- ☐ Learning Disability - Moderate
- ☐ Learning Disability - Other, please state in details box
- ☐ Learning Disability - Severe
- ☐ Mental Health - Anxiety
- ☐ Mental Health - Dementia / Alzheimers
- ☐ Mental Health - Depression / Bipolar Disorders
- ☐ Mental Health - Korsekoffs Syndrome
- ☐ Mental Health - Obsessive Compulsive Disorder
- ☐ Mental Health - Other, please state in details box
- ☐ Mental Health - Phobias
- ☐ Mental Health - Schizophrenia / Personality Disorders
- ☐ Other Vulnerability - Other, please state in details box
- ☐ Other Vulnerability - Self Neglect
- ☐ Other Vulnerability - Vulnerable to Exploitation/Abuse
- ☐ Physical/Sensory/Frailty - Acquired Brain Injury
- ☐ Physical/Sensory/Frailty - Cerebral Palsy
- ☐ Physical/Sensory/Frailty - Difficulties with daily living tasks/mobility
- ☐ Physical/Sensory/Frailty - Dual Sensory Impairment
- ☐ Physical/Sensory/Frailty - Hearing Impairment
- ☐ Physical/Sensory/Frailty - Neurological Conditions, please state in details box
- ☐ Physical/Sensory/Frailty - Other, please state in details box
- ☐ Physical/Sensory/Frailty - Paraplegia/Quadriplegia/Hemiplegia
- ☐ Physical/Sensory/Frailty - Visual Impairment
- ☐ Substance Misuse - Alcohol
- ☐ Substance Misuse - Alcohol and Drugs
- ☐ Substance Misuse - Drugs

SECTION 3B Disability Assessment Visit
Customer name:
PROTOCOL Number:
Name of Worker:
Date of Screening:
People present at assessment:
Go through and verify info already gathered on Section 1 and amend if required.

FACS Eligibility Screening Tool	
Threshold set at CRITICAL	
They need help to carry out all aspects of personal care or domestic tasks	
They need help to be involved in work, education, learning and in the community that is vital to their independence	
They need help to keep relationships vital to their independence	
They need help to keep family and other social roles and responsibilities vital to their independence	
They have experienced serious abuse or neglect	
They feel they have no choice and control over the world around them	
They have significant health problems	
Their life is at risk	
Threshold set at SUBSTANTIAL	
They need help to carry out most personal care or domestic tasks	
They need help to be involved in many aspects of work, education, learning and in the community	
They need help to maintain most of their important relationships	
They need help to keep most of their family and other social roles and responsibilities	

They at risk of being abused or neglected	
They feel they have only partial choice and control over the world around them	
Threshold set at MODERATE	
They need help to carry out several personal care or domestic tasks	
They need help to be involved in several aspects of work, education, learning or in the community	
They need help to maintain several important relationships	
They need help to keep several family and other social roles and responsibilities.	
Threshold set at LOW	
They need help to carry out one or two personal care or domestic tasks	
They need help to be involved in one or two aspects of work, education, learning or in the community	
They need help to maintain important relationships	

In order to be eligible for social care services, an individual must meet at least one of the criteria in either the CRITICAL or SUBSTANTIAL domains ONLY.	
Does the customer meet Fair Access to Care Services (FACS)?	☐ Yes ☐ No

I have had the assessment process explained to me and consent to this assessment. I am aware that other professionals from other agencies such as my GP, District Nurse and Health Providers may share this information. ☐ Yes ☐ No
Signed: (Customer / Assigned Person)*
Date:
*if not signed, please state reason why:
Are there any persons who you would not wish us to share this information with? ☐ Yes ☐ No
If yes, please give details:
Following an assessment of my needs, it has been explained to me that any services being offered to me may be subject to an assessment of my ability to contribute towards the cost of this service and that I may be visited by a Financial Assessment Officer.
☐ Yes ☐ No Signed (Customer / Assigned Person) *

Date:	

*if not signed, please state reason why:
Recommendation of Assessing Officer:
Summary of identified needs/recommendation of Assessing Officer (in addition to info pulled through from S2C):
☐ Referral to HIA Minor Adaptations (complete and attach in PROTOCOL HIA MINOR referral)
☐ Referral to HIA Major Adaptations (complete and attach in PROTOCOL HIA MAJOR referral)
☐ Referral to HIA Feasibility Study (complete and attach in PROTOCOL Feasibility Study doc)
☐ Specification Document for Level Access Shower (complete and attach in PROTOCOL form)
☐ Specification Document for Ramp (complete and attach in PROTOCOL form)
☐ Specification Document for Stair lift (complete and attach in PROTOCOL form)
☐ Specification Document for Closomat (complete and attach in PROTOCOL form)
☐ Specification Document for Shower Over Bath (complete and attach in PROTOCOL form)
☐ Specification Document for Through Floor Lift (complete and attach in PROTOCOL Form)
☐ H2A Equipment Order (complete and attach in PROTOCOL form)
☐ Bed Lever Risk Assessment (complete and attach in PROTOCOL form)
☐ Chair/ Bed Raiser Spec (complete and attach in PROTOCOL form)
☐ Closure Letter (complete letter and attach in PROTOCOL)
☐ No Contact Letter (complete letter and attach in PROTOCOL)
☐ Letter Requesting medical Information (complete letter and attach in PROTOCOL)
☐ Consent letter to Obtain Medical Information (complete letter and attach in PROTOCOL)
Customer Notifications:
☐ Recommendations discussed with customer
☐ Recommendations Letter (complete letter and attach in PROTOCOL)

Assessing Practitioner:	
Job Title:	

Date assessment started:	
Date assessment completed:	
Assessment Outcome:	
☐ Assessment cancelled ☐ Cancelled/Client Died ☐ Cancelled/Client Moved ☐ Further Assessment ☐ New services offered but declined ☐ NFA- No (new) services offered or intended to be provided ☐ No new services offered or intended ☐ Some new services intended but not yet started ☐ Some or all services already started (including those started and finished) ☐ Other Sequel to Assessment	

SECTION 3C Visual Impairment Assessment Visit
Customer name:
PROTOCOL Number:
Name of Worker:
Date of Screening:
Go through and verify info already gathered on Section 1and amend as required.
Do you have a dual sensory loss? Yes No
Eye condition: (including treatment)
Visual Acuity: R/E L/E
Hearing Loss details
Psychological support ☐ Yes ☐ No If Yes, details:

FACS Eligibility Screening Tool	
Threshold set at CRITICAL	
They need help to carry out all aspects of personal care or domestic tasks	
They need help to be involved in work, education, learning and in the community that is vital to their independence	
They need help to keep relationships vital to their independence	
They need help to keep family and other social roles and responsibilities vital to their independence	
They have experienced serious abuse or neglect	
They feel they have no choice and control over the world around them	
They have significant health problems	
Their life is at risk	
Threshold set at SUBSTANTIAL	
They need help to carry out most personal care or domestic tasks	
They need help to be involved in many aspects of work, education, learning and in the community	
They need help to maintain most of their important relationships	
They need help to keep most of their family and other social roles and responsibilities	
They at risk of being abused or neglected	
They feel they have only partial choice and control over the world around them	
Threshold set at MODERATE	
They need help to carry out several personal care or domestic tasks	
They need help to be involved in several aspects of work, education, learning or in the community	
They need help to maintain several important relationships	
They need help to keep several family and other social roles and responsibilities.	
Threshold set at LOW	
They need help to carry out one or two personal care or domestic tasks	
They need help to be involved in one or two aspects of work, education, learning or in the community	
They need help to maintain important relationships	

In order to be eligible for social care services, an individual must meet at least one of the criteria in either the CRITICAL or SUBSTANTIAL domains ONLY.	
Does the customer meet Fair Access to Care Services (FACS)?	☐ Yes ☐ No

I have had the assessment process explained to me and consent to this assessment. I am aware that other professionals from other agencies such as my GP, District Nurse and Health Providers may share this information. ☐ Yes ☐ No	
Signed: (Customer / Assigned Person)*	
Date:	
*if not signed, please state reason why:	
Are there any persons who you would not wish us to share this information with? ☐ Yes ☐ No	
If yes, please give details:	
Following an assessment of my needs, it has been explained to me that any services being offered to me may be subject to an assessment of my ability to contribute towards the cost of this service and that I may be visited by a Financial Assessment Officer.	
Signed (Customer / Assigned Person)*:	
Date:	
*if not signed, please state reason why:	
Recommendation of Assessing Officer:	
Summary of identified needs/recommendation of Assessing Officer:	
Referral to: (Visual Impairment) ☐ Action for Blind ☐ Speakeasy ☐ Low Vision Clinic ☐ Bury Society for Blind and Partially Sighted People ☐ Pipeline ☐ Community Mental Health Team ☐ Other (Specify)	

Assessment Outcome
☐ Assessment cancelled ☐ Cancelled/Client Died ☐ Cancelled/Client Moved ☐ Further Assessment ☐ New services offered but declined ☐ NFA- No (new) services offered or intended to be provided ☐ No new services offered or intended ☐ Some new services intended but not yet started ☐ Some or all services already started (including those started and finished) ☐ Other Sequel to Assessment

SECTION 3D
Hearing Impairment Assessment Visit

Customer name:

PROTOCOL Number:

Name of Worker:

Date of Screening:

Go through and verify info already gathered on Section 1 and amend as required

Do you have a dual sensory loss? Yes No

Hearing Rehabilitation

Hearing loss- ☐ mild ☐ moderate ☐ severe ☐ profound

Type of hearing loss- ☐ sensori-neural ☐ conductive ☐ combined

Cause of hearing loss:

Age of onset:

Hearing aid (s)- ☐ Left ☐ Right ☐ NHS ☐ Private Date fitted:

Usefulness/insertion/controls:

Speech- ☐ normal ☐ intelligible ☐ unintelligible ☐ none

Tinnitus- ☐ mild ☐ tolerable ☐ severe ☐ occasional ☐ frequent ☐ constant

What does it sound like?

Onset- date it started

Advice re: tinnitus:
Referred to GP for referral to Tinnitus clinic ☐ Yes ☐ No
Communication
Advice given regarding hearing loss:
Information on hearing tactics and ways of coping:
Listening practice:
Environmental sounds:
One to one:
Environmental issues e.g. lighting, background noise
Lipreading- ☐ skilled ☐ average ☐ poor ☐ unable
Advice re lipreading/class/leaflet:
Specialist equipment tried: (see section 2C)
Abilities / interests / lifestyle

FACS Eligibility Screening Tool	
Threshold set at CRITICAL	
They need help to carry out all aspects of personal care or domestic tasks	
They need help to be involved in work, education, learning and in the community that is vital to their independence	
They need help to keep relationships vital to their independence	
They need help to keep family and other social roles and responsibilities vital to their independence	
They have experienced serious abuse or neglect	
They feel they have no choice and control over the world around them	
They have significant health problems	
Their life is at risk	
Threshold set at SUBSTANTIAL	
They need help to carry out most personal care or domestic tasks	
They need help to be involved in many aspects of work, education, learning and in the community	
They need help to maintain most of their important relationships	
They need help to keep most of their family and other social roles and responsibilities	
They at risk of being abused or neglected	
They feel they have only partial choice and control over the world around them	
Threshold set at MODERATE	
They need help to carry out several personal care or domestic tasks	
They need help to be involved in several aspects of work, education, learning or in the community	
They need help to maintain several important relationships	
They need help to keep several family and other social roles and responsibilities.	
Threshold set at LOW	
They need help to carry out one or two personal care or domestic tasks	
They need help to be involved in one or two aspects of work, education, learning or in the community	
They need help to maintain important relationships	

In order to be eligible for social care services, an individual must meet at least one of the criteria in either the CRITICAL or SUBSTANTIAL domains ONLY.	
Does the customer meet Fair Access to Care Services (FACS)?	☐ Yes ☐ No

I have had the assessment process explained to me and consent to this assessment. I am aware that other professionals from other agencies such as my GP, District Nurse and Health Providers may share this information. ☐ Yes ☐ No
Signed: (Customer / Assigned Person)*
Date:
*if not signed, please state reason why:
Are there any persons who you would not wish us to share this information with? ☐ Yes ☐ No
If yes, please give details:
Following an assessment of my needs, it has been explained to me that any services being offered to me may be subject to an assessment of my ability to contribute towards the cost of this service and that I may be visited by a Financial Assessment Officer.
Signed (Customer / Assigned Person) *
Date:
*if not signed, please state reason why:
Recommendation of Assessing Officer:
Summary of identified needs/recommendation of Assessing Officer:

Referral to: (Hearing Impairment)

- ☐ Bury ASC Specialist SW
- ☐ Community Occupational Therapy
- ☐ Bury ASC Assessment and Reintegration Team (Disability)
- ☐ Day care
- ☐ Community Mental Health Team
- ☐ Physiotherapy
- ☐ Other (Specify)

Assessment Outcome

- ☐ Assessment cancelled
- ☐ Cancelled/Client Died
- ☐ Cancelled/Client Moved
- ☐ Further Assessment
- ☐ New services offered but declined
- ☐ NFA- No (new) services offered or intended to be provided
- ☐ No new services offered or intended
- ☐ Some new services intended but not yet started
- ☐ Some or all services already started (including those started and finished)
- ☐ Other Sequel to Assessment

This Section Is To Be Completed If You Have Someone That Cares For You.

Personal Details of Carer	
Name	
Address	
Postcode	
Contact Number(s)	
Email Address	
Date of Birth	

A Carer's Assessment is a conversation which aims to establish what services and support would be helpful in your particular situation. We have two types of Carers Assessment;

1. *My Initial Carers Assessment* – is used to gather some brief information about your caring role and offer you some information, advice and guidance, where required.

2. *Formal Carers Assessment* - is your opportunity to talk about your caring role in detail, how it affects your daily life and what support you need in the future.

Have you had completed the Initial Carers Assessment? **Yes** ☐ **No** ☐
Have you had completed the Formal Carers Assessment? **Yes** ☐ **No** ☐
If NO to either of these would you like either an; • Initial Carers Assessment **Yes** ☐ **No** ☐ • Formal Carers Assessment **Yes** ☐ **No** ☐

Adult Care Services staff to ensure that Carers Assessments are completed as soon as possible if required.