# SACRED HEART REHABILITATION

## REHAB IN THE HOME (RITH)
### INITIAL ASSESSMENT

Date of Assessment: _____________________  Rehab Specialist: ____________________

### MEDICAL HISTORY

Current:
__________________________________________________________
__________________________________________________________

Previous:
__________________________________________________________
__________________________________________________________

Precautions:
__________________________________________________________

### SOCIAL SITUATION

**Social/Cultural:**
- Country of Birth: ___________________
- Language: ___________________

- Married/De Facto
- Divorced
- Widowed
- Single
- No. of Children: ___________________
- Lives alone
- Family members in home: ___________________

Comments: __________________________________________________________________________

**Family/Social Support:**
- Strong
- Limited
- Nil

- NOK: ___________________
- Relationship to client: ___________________

**Carer/Community Support:**
- Has sole carer
- Home Care
- DVA
- MOW
- Home respite
- Compacks
- Transport
- Nil

Comments: __________________________________________________________________________

- Personal Alarm:
- Yes
- No

- Guardian
- Enduring POA
- Advanced Care Directive

Details: _____________________________________________________________________________

### HOME ENVIRONMENT

**Description**

- House Structure:  
  - Single
  - Double
  - Unit
  - Other: ___________________

- House Ownership:  
  - Own
  - Rented
  - DOH
  - R/V
  - Hostel

Comments: __________________________________________________________________________

**Access**

- Front: No of steps ____________ Rails ascending:  
  - R
  - L
  - Bilateral
  - Nil

- Back: No of steps ____________ Rails ascending:  
  - R
  - L
  - Bilateral
  - Nil

- Inside: No of steps ____________ Rails ascending:  
  - R
  - L
  - Bilateral
  - Nil

Comments: __________________________________________________________________________

**Usual Bathroom:** (shower, hob, bath, toilet etc)

__________________________________________________________________________________

Comments: __________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________
## Self Care

<table>
<thead>
<tr>
<th>Previous Function</th>
<th>Current Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating:</td>
<td></td>
</tr>
<tr>
<td>Showering:</td>
<td></td>
</tr>
<tr>
<td>Dressing:</td>
<td></td>
</tr>
<tr>
<td>Grooming:</td>
<td></td>
</tr>
<tr>
<td>Toileting:</td>
<td></td>
</tr>
<tr>
<td>Continence:</td>
<td></td>
</tr>
</tbody>
</table>

Comments: _________________________________________________________________________

## Domestic & Household Management

<table>
<thead>
<tr>
<th>Previous Function</th>
<th>Current Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooking:</td>
<td></td>
</tr>
<tr>
<td>Cleaning:</td>
<td></td>
</tr>
<tr>
<td>Laundry:</td>
<td></td>
</tr>
<tr>
<td>Gardening:</td>
<td></td>
</tr>
<tr>
<td>Shopping:</td>
<td></td>
</tr>
<tr>
<td>Finances:</td>
<td></td>
</tr>
<tr>
<td>Method of banking:</td>
<td></td>
</tr>
<tr>
<td>Medications:</td>
<td></td>
</tr>
</tbody>
</table>

Comments: _________________________________________________________________________

## Employment

Occupation: __________________________________

- [ ] Currently working
- [ ] Full time
- [ ] Part time
- [ ] Unemployed
- [ ] Retired
- [ ] Volunteer

Pension: [ ] Yes [ ] No

Type:______________________________________

Comments:

## Community Activities

Frequency of Outings: _________________________________________________________________

Type of outings/activities (eg. Dr appt’s): ___________________________________________

Level of Assistance required: [ ] Independent [ ] Supervision [ ] Assistance

Comments: _________________________________________________________________________

## Transport

Current Drivers Licence: [ ] Yes [ ] No

Outstanding Driving Issues: [ ] Yes [ ] No

Currently Driving: [ ] Yes [ ] No

Driving Assessment Required: [ ] Yes [ ] No

Public Transport: [ ] Yes [ ] No

Type:_____________________________________

[ ] Independent [ ] Supervision [ ] Assistance

Comments: _________________________________________________________________________
**Computer Use**
Access to a computer: □ Yes  □ No  
Frequency of use: □ High  □ Moderate  □ Minimal  □ Nil
Problems/Comments: ____________________________________________

**Handwriting:**
Dominance: □ Right  □ Left  
Affected: □ Right  □ Left  
Problems: □ Yes  □ No
Comments: ____________________________________________

**Leisure:**
Sleep/Rest: ____________________________________________

**CARDIORESPIRATORY FUNCTION**
Comments: ____________________________________________

**FUNCTIONAL ASSESSMENT**

**Transfers**

<table>
<thead>
<tr>
<th>Previous function</th>
<th>Current function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed transfers:</td>
<td></td>
</tr>
<tr>
<td>Chair transfers:</td>
<td></td>
</tr>
<tr>
<td>Toilet transfers:</td>
<td></td>
</tr>
<tr>
<td>Shower transfers:</td>
<td></td>
</tr>
<tr>
<td>Car transfers:</td>
<td></td>
</tr>
</tbody>
</table>

Comments: ____________________________________________

**Mobility/Balance**

<table>
<thead>
<tr>
<th>Previous function</th>
<th>Current function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indoor mobility:</td>
<td></td>
</tr>
<tr>
<td>Outdoor mobility:</td>
<td></td>
</tr>
<tr>
<td>Outcome measures:</td>
<td></td>
</tr>
<tr>
<td>Stairs:</td>
<td></td>
</tr>
<tr>
<td>Sitting balance:</td>
<td></td>
</tr>
<tr>
<td>Standing balance (static/dynamic)</td>
<td></td>
</tr>
</tbody>
</table>

Comments: ____________________________________________

**SENSORY FUNCTION**

<table>
<thead>
<tr>
<th>Visual issues: □ Yes  □ No</th>
<th>Glasses: □ Yes  □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing impairment: □ Yes  □ No</td>
<td>Aids: □ Yes  □ No</td>
</tr>
<tr>
<td>Sensory Impairment: □ Yes  □ No</td>
<td></td>
</tr>
<tr>
<td>Visual Perceptual Deficits: □ Yes  □ No</td>
<td></td>
</tr>
<tr>
<td>Proprioceptive Deficits: □ Yes  □ No</td>
<td></td>
</tr>
</tbody>
</table>

Comments: ____________________________________________
### MOTOR FUNCTION

**Upper limb:**

**Lower limb:**

### COGNITIVE FUNCTION

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehension deficits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expression deficits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to follow commands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results of previous Ax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### RISK ASSESSMENT

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder subluxation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair/seating issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oedema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### GOALS:

____________________________________________________________________________________
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### PLAN:

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