St Vincent's Hospital

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: _____
_____
_____

OCCUPATIONAL PERFORMANCE AREAS

Self Care

	Previous Function	Current Function
Eating:		
Showering:		
Dressing:		
Grooming:		
Toileting:		
Continence:		

Comments: _____

Domestic & Household Management

	Previous Function	Current Function
Cooking:		
Cleaning:		
Laundry:		
Gardening:		
Shopping:		
Finances: Method of banking:		
Medications:		

Comments: _____

<u>Employment</u>

Occupation: _____

☐Currently working ☐Full time ☐Part time ☐Unemployed ☐Retired ☐Volunteer

Pension: ☐Yes ☐ No Type:_____

Comments:

<u>Community Activities</u>

Frequency of Outings: _____

Type of outings/activities (eg. Dr appt's): _____

Level of Assistance required: ☐Independent ☐Supervision ☐Assistance

Comments: _____

<u>Transport</u>

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

	Previous function	**Current function**
Bed transfers:		
Chair transfers:		
Toilet transfers:		
Shower transfers:		
Car transfers:		

Comments: _____

Mobility/Balance

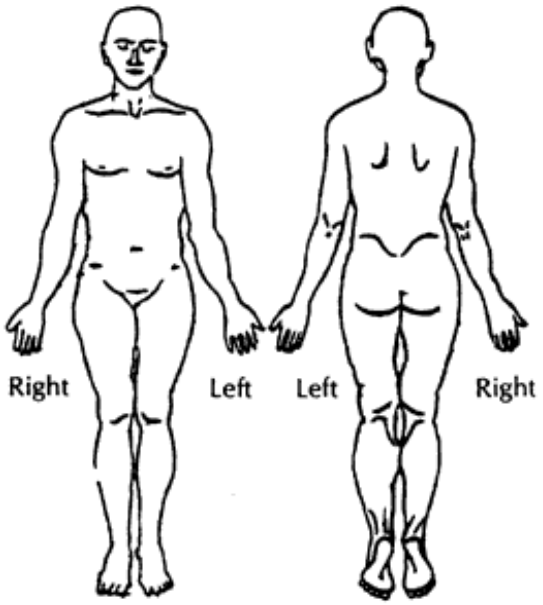
	Previous function	**Current function**
Indoor mobility:		
Outdoor mobility:		
Outcome measures:		
Stairs:		
Sitting balance:		
Standing balance (static/dynamic)		

Comments: _____

SENSORY FUNCTION

Visual issues: ☐Yes ☐No Glasses: ☐Yes ☐No
Hearing impairment: ☐Yes ☐No Aids: ☐Yes ☐No
Sensory Impairment: ☐Yes ☐No _____
Visual Perceptual Deficits: ☐Yes ☐No _____
Proprioceptive Deficits: ☐Yes ☐No _____
Comments:_____

MOTOR FUNCTION



Upper limb:

Lower limb:

COGNITIVE FUNCTION

Comprehension deficits: ☐Yes ☐No _____
Expression deficits: ☐Yes ☐No _____
Able to follow commands: ☐Yes ☐No_____
Orientated: ☐Yes ☐No_____
Results of previous Ax: ☐Yes ☐No_____
Comments: _____

RISK ASSESSMENT

Falls risk: ☐Yes ☐No _____
Shoulder subluxation: ☐Yes ☐No _____
Wound care: ☐Yes ☐No _____
Pressure care: ☐Yes ☐No _____
Wheelchair/seating issues: ☐Yes ☐No _____
Oedema: ☐Yes ☐No _____
Pain: ☐Yes ☐No Location: _____
Comments: _____

GOALS:

_____
_____
_____
_____
_____
_____
_____
_____

PLAN:

_____
_____
_____
_____
_____