DoB:

Single Assessment Tool

Client

Date/time

(NB: This may form part of an assessment under the Care Programme Approach and/or Section

Link to referral if appropriate

Referral information (click help icon to view additional information)

PART A

Where is the form being initiated ? Please Select

Capacity, Communication and Consent

Mental Capacity is presumed in accordance with the Mental Capacity Act 2005

(invalid configuration)

Is there any reason, at the time of assessment, to doubt Mental Capacity? ○Yes ○No

If the person lacks Mental Capacity to consent, a discussion with carers/family should take plac information will be exchanged (this must form part of a care plan)

(invalid configuration)

Is a full assessment of Mental Capacity required? ○Yes ○No

(invalid configuration)

If yes, please specify below, including whether there are any applicable actions / processes to be DOLS / Best Interest / Capacity assessment)

Preferred form of communication (any specific preferences i.e. face to face, and / or with an Adv

Any additional communication / other needs (including factors that may impact on engagement)? Please Select

If yes, please specify and outline arrangements to be made (i.e. literacy needs, interpreters, signe

Do you consider yourself to have a disability? ○Yes ○No

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If yes, provide further information.

Can we contact you in the following ways ?

Call you at home?	○ Yes ○ No
Leave message on home (landline) voicemail?	○ Yes ○ No
Leave message with a family member?	○ Yes ○ No

Name	Relationship	C

Call your mobile?	○ Yes ○ No
Leave message on mobile voicemail?	○ Yes ○ No
Contact you at your workplace?	○ Yes ○ No
Leave a message with workplace?	○ Yes ○ No
Send letter to home address?	○ Yes ○ No
Contact you via email?	○ Yes ○ No

If yes, please specify email address to contact

Send text message to mobile with reminder of appointment?	○ Yes ○ No
Patient has agreed the communication information is accurate and has given their consent to be contacted by the ways outlined above?	○ Yes ○ No

Were Consent and Information Sharing discussed with the Service User?	○ Yes ○ No
Is there a Carer / Significant other identified that can be contacted for information ?	○ Yes ○ No
Were Consent and Information Sharing discussed with Carer / Family member / Significant other?	○ Yes ○ No

If a person does not consent to carer/family member/significant other being asked for their vie still be contacted in order to undertake an assessment, if a Practitioner has any concerns about a

Has the Carer / Significant other given permission for their details to be recorded on Health & Social Care IT Systems?	○ Yes ○ No
If Yes, has a Carers Assessment been offered?	○ Yes ○ No

16 - 64 only, If aged 65+, assessment will be undertaken by other relevant authority (i.e. SSOTI

If offered, has the Carers Assessment been declined ?	○ Yes ○ No

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Did the Carer / Significant other contribute to the assessment? ○ Yes ○ No

Does this assessment take into account the Carers / Family member / Significant Other views? ○ Yes ○ No

Advance Decision

Has the person made an Advance Decision or Advance Statement? Please Select

If Yes, give date and location

ABC

Has a copy been scanned into the Health & Social Care Record? ○ Yes ○ No

Has the Service User made a Do Not Resuscitate statement? ○ Yes ○ No

If Yes, provide further details

ABC

Has a copy been scanned into the Health and Social Care Record? ○ Yes ○ No

Hazards/Risk Factors (at time of assessment)

Have any issues that jeopardise the safety of the service user or other people been identified at time of assessment? ○ Yes ○ No

(complete Risk Assessment Document in core document set)

Current Family Circumstances

Does anyone else live at home with you? Please Select

Name	Relationship	Date of Birth (if applicable)

Carer Details

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Is there a Nominated Carer for the Referred Person identified? Please Select

Name	Relationship	Date of Birth (if applicable)

Is the Referred Person a Carer for anyone else? Please Select

Name	Relationship	Date of Birth (if applicable)

Is the carer identified as a young (under 18) Carer? ◯ Yes ◯ No

Name	Relationship	Date of birth

please note if 'Yes' an automatic notification will go to Safeguarding Team

Safeguarding:

Does the Service User have substantial contact with a child not in the household? ◯ Yes ◯ No

Name	Address	Date of Birth	Rel

How does the Service User's illness / condition impact on the child / ren / dependant adult

Are there any risks to the child / ren / dependant adult? ◯ Yes ◯ No

If yes, provide any detail and reflect in the risk assessment and care plan.

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Does the Service User require any support in caring for the child / ren / dependant adult? ○Yes ○No

If yes provide details

Is there anyone who shares the caring role (i.e. Partner, extended Family)? ○Yes ○No

Name	Date of birth if applicable	Relationship

Are any Agencies involved with the child/ ren / dependant adult? ○Yes ○No

Name	Role	Organisation

Is the Service User /Child / ren / Dependant Adult subject to any current Safeguarding procedures ? ○Yes ○No

If yes provide detail.

Has the Service User been subject to MARAC (Multi Agency Risk Assessment Conference) ? ○Yes ○No

If yes provide detail.

Military History

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Is there any history of Military Service? Please Select

If yes, would you like a member of the Veterans service to make contact with you? Please Select

Other Agency involvement.

Are any other Services / Agencies currently involved (including other mental health services)? ○ Yes ○ No

Consider involvement with statutory and non statutory organisations, social support (i.e. family support

Agency	Contact name	Role

Past contact with Services / Agencies? ○ Yes ○ No

Consider involvement with statutory and non statutory organisations, social support (i.e. family support

Agency	Contact name	Role

Previous admissions Please Select

If yes, please provide details if known (including legal status on admission)

From any past involvement, what has helped before?

PARTB

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Summary of Current mental health problems (including how they impact on current functioning, s by the referred person and to significant others).

Reasons for referral (i.e. Current presenting mental health difficulties and symptoms; impact on fi being experienced by the person and to significant others)

Expectations of Service User (If known at time of assessment - i.e. what they would like the outco wellbeing & recovery)

Expectations of Referrer(If different from above)

Expectations of Carer / Family / Significant Other (If different from above)

Which problems are most upsetting for you?

When did you last feel well?

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Have there been any important recent changes in your life? (include both positive and negative si

Medication

Current medication, please provide details i.e. consider Medication/s that are prescribed, over family/friends?

Do you have any issues with taking medication? ◯ Yes ◯ No

If Yes please specify

Medicine	Dose	Frequency

Past Medication, please provide details i.e. consider Medication/s that are prescribed, over cou family/friends?

Medicine	Dose	Frequency

Details of any contra-indications, allergies, drug reactions

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Is the person currently involved in any Clinical Trials? Please Select

If yes please provide detail

Mental State

Appearance & Behaviour (consider posture & movement, level of distraction, restlessness, repetit etc. level of rapport, non-verbal communication)

Mood (consider elation, persistent low mood, intermittent low mood, diurnal variation, elation, hc reduced energy levels, triggers).

Volition (consider desire, choice, decision making ability - thought content, overvalued beliefs or

Perception and Thought (consider experience of hallucinations, delusions, disturbances of percep

Speech & Language (consider all aspects of communication including fluency, rate & tone, content

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ABC

Mood & Affect (consider persistently low, intermittently low, diurnal variation, elation, hopelessn energy levels, triggers).

ABC

Cognitive Function (consider memory, concentration, attention, information processing).

ABC

Sleep (consider no problem, initial insomnia, frequent waking, early morning waking)

ABC

Insight (understanding/rationale for their issues)

ABC

Mental Health History (Consider previous involvement, diagnosis, treatment, current treatment, symptoms (psychosis, depression, anxiety etc.include an

ABC

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Strengths & abilities

Family Circumstances and Personal information (consider current and histor Childhood development, Educational history - schooling, truancy, achieveme names and dob of children. Relationships and social contacts/network. Socia Spiritual needs

Have you experienced physical, sexual, emotional abuse or domestic violence at any time in your life? Please Select

add reason for not asking

if yes please provide brief detail of any disclosure

Has a MARAC referral been considered/processed, if domestic violence is an issue? ○ Yes ○ No

if yes please provide detail

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Forensic Details (include convictions, outstanding/impending court cases, cu injunctions)

Are there any known offences against children?

ABC

if yes please provide detail

ABC

Military Service (include unit/length of service, any active service details, cc

ABC

Physical/Medical Information (consider current and historical detail and fami

History of Venothromboembolism ○ Yes ○ No

Comments

ABC

Risk of Venothromboembolism ○ Yes ○ No

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Comments

ABC

.	Yes/no	If y
Any recent operations	◯ Yes ◯ No	
Chronic Physical illness	◯ Yes ◯ No	
Any Mobility problems	◯ Yes ◯ No	
History of falls	◯ Yes ◯ No	
Exercise/activities	◯ Yes ◯ No	
Any known allergies or sensitivities	◯ Yes ◯ No	
Sensory impairment	◯ Yes ◯ No	
Special Dietary requirements	◯ Yes ◯ No	
Pending appointments	◯ Yes ◯ No	
Existing conditions(i.e. diabetes, heart problems)	◯ Yes ◯ No	

.	YES / NO	DATES	FREQUENCY	AMC
Cigarettes	◯ Yes ◯ No			
Alcohol	◯ Yes ◯ No			
Drugs	◯ Yes ◯ No			
Solvents	◯ Yes ◯ No			

Pregnancy & Maternity

Are you currently pregnant? Please Select

If yes, what is the expected birth date

Have you recently given birth? Please Select

If yes, what is the date of birth of child

Are you currently breast feeding? Please Select

Number of pregnancies (gravida)?

Number of children (para)?

Number of terminations?

Number of miscarriages?

Are your vaccinations up todate? ◯ Yes ◯ No

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What are your expectations of motherhood?

ABC

Date of most recent physical health check and details if known

ABC

Family Medical History

ABC

PART C

Employment detail (include detail regarding current employment status, Occupation/s/Jobs, re retirement detail, student detail, difficulties with employment).

Employed Please Select

If employed , hours worked Please Select

Please include any relevant detail

ABC

Does the service user wish to explore support with access to employment / employment activity? ○ Yes ○ No

(If Yes, ensure a care plan documents the support being offered?)

If No, is there evidence that the service user has been signposted / supported to pre-employment activity? ○ Yes ○ No

Provide Detail

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Financial Information (include detail - income source, debts, outstanding fin

Benefits recieved

DLA	☐
Income support	☐
Incapacity benefit	☐
Severe Disability Allowance	☐
Attendance Allowance	☐
State Retirement Pension	☐
Housing Benefit	☐

Other- please provide details

Details of amounts if known

Do you pay council tax? ○ Yes ○ No

If yes, to which council (include detail)

Accommodation detail

Household Please Select

Provide any relevant detail

Accomodation Status Please Select

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Type of Accomodation Please Select

If other, provide detail

Number of bedrooms?

Is the home heated? ◯ Yes ◯ No

Are there any issues with the accommodation?

Daily Living Skills / Personal Care (please consider mobility - use of own transport, car owner / laundry, dressing, eating, drinking, budgeting, shopping, risk of neglect etc.).

Fair Access to Care Services

Eligibility for community care funded services should only be determined when sufficient asses evaluated. To determine which 'presenting needs' are eligible, the Department of Health's 'Fair A applied to each outstanding need identified by the assessment process. The FACS Determination T used to assist the determination of a Service Users presenting needs which may be eligible for fun should be attributed in each case e.g. C1, S2, M3, L1.

Has FACS Eligibility Criteria been met? (Use Local Authority Eligibility Matrix to assist in the determination) ◯ Yes ◯ No

If FACS Eligibility Criteria have been met, has the Direct Payments process been explained to the Service User ◯ Yes ◯ No

if no provide details

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NHS CONTINUING HEALTHCARE (complete if necessary) If the assessment indicates that the Ser additional package beyond the services provided by the Community Team, complete the NHS Cont determination of eligibility and follow the relevant policy / procedure for CHC funded services.

Has NHS Continuing Healthcare Eligibility Criteria been met? (Use NHS CHC criteria to assist the determination) ☐

Note: Determination of eligibility for either Local Authority of Healthcare funded services will associated evidence has been presented to the respective funding panels and agreed by its memb

PART D

Information Leaflets

Click here for initial decision guide

Summary of Assessment and Current Need

Does the Service User want information relating to the following (if yes, provide with leaflets)

Comments, Compliments & Complaints Procedure	○ Yes ○ No
Freedom of Information Act	○ Yes ○ No
Data Protection 1998 - Access to Healthcare Records	○ Yes ○ No
Advocacy Service	○ Yes ○ No
PALS Information	○ Yes ○ No
If the person lacks mental capacity to understand any of the above, has the information been sent to a third party?	○ Yes ○ No

Please specify any additional information leaflets offered at time of assessment (including Carers I

Statements

I have been involved in this assessment and agree with it's content. I also

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understand that my record will be shared with Professionals / Providers directly involved in my care and wellbeing.	◯ Yes ◯ No
I have completed the self-assessment that I received and agree to a copy forming part of my records	◯ Yes ◯ No
I have declined a copy of this assessment (if yes, include date)	◯ Yes ◯ No
I would like to receive a copy of the assessment document (if yes, include date given / sent)	◯ Yes ◯ No

Assessment copies

A copy of the assessment must also be offered / sent to:

Co-workers external to the Trust (please specify)

Name	Role	Organisation

Other person, identified by the Service User (please specify)

Name	Role	Organisation

If the Service User lacks Mental Capacity, a copy of the assessment must be s their best interests (please specify)

Name	Role	Organisation

OUTCOME OF ASSESSMENT

	TICK ONE OR MORE THAT APPLY
Service Started	☐
Service intended but not yet started	☐
Service offered but declined	☐
Assessment completed but no service offered	☐
Assessment completed and redirected to other services	☐
Assessment completed CPA required	☐
Assessment terminated for other reason	☐
Unmet needs	☐
Needs met by FACS eligibility criteria	☐
Admitted to hospital / alternative placement	

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	☐
Safeguarding Procedures commenced	☐
Carer Assessment requested	☐
Veterans referral commenced	☐
Appropriate Adult Intervention	☐
Referred to other services (external to Trust)	☐
Signpost to other services (external to Trust)	☐
No further action required, discharged from service	☐