COMMON SUMMARY ASSESSMENT REPORT

Please complete all sections clearly in block capitals. Read guidance notes before completing

I confirm that the assessment process and purpose has been explained to me. I consent that information may be shared as appropriate by relevant health and social care professionals in the processing of this application.

Signature _____ **Applicant/Specified Person Date** _____
(Delete as appropriate)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

1. SOURCE OF REFERRAL (PLEASE TICK):

Community Hospital ☐ Acute Hospital ☐ GP ☐
Mental Health ☐ Community ☐ Nursing Home ☐
Name of Referring Location: _____ Date of Referral: _____

2. PERSONAL DETAILS:

First Name: _____ Surname(s): _____ Preferred Name: _____

Current Address: _____ Home/Past Address (If relevant): _____ Tel No(s): _____

_____ _____ Date of Birth (DD/MM/YYYY)

Medical Card No: _____ Hospital Number: _____ _____

PPS No. : _____

3. PERSONAL CIRCUMSTANCES:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other
Living Circumstance: ☐ Alone ☐ With Spouse ☐ With partner ☐ With family ☐ With carer ☐ With Other

Describe Housing situation (See guidance document):

Who is the Principal Carer: _____

What level of support do they provide?
(Please include contact details):

Assessment of Carer's needs completed? Yes ☐ No ☐ (Please attach if available)

Identify any family members, neighbours, friends who provide support:

Contact Person/Specified Person/Care Rep: _____ Relationship to applicant?
(Contact details address/phone/mobile): _____ _____

_____

GP: _____ Contact Details: _____
PHN &/or CMHN: _____ Contact Details Health Centre: _____

4. ALL APPLICANTS have the right to self-determination and capacity to do so is assumed unless otherwise proven.

His/her preference to stay at home or to be admitted to residential long-term care must be sought and recorded.

Has the person's above preference been discussed with him/her? **Yes** ☐ **No** ☐

If YES - brief outline of outcome

_____

_____

If No - Provide a reason and identify with whom it has been discussed & outline outcome

_____

_____

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

5. RECORD OF CURRENT COMMUNITY/HOME SUPPORT SERVICES (See Guidance Document before completing):

SERVICE (Tick)	Home Help/Support ☐	Day Care ☐	Respite ☐	Meals Supply ☐	Laundry ☐	Aids and Appliances ☐
Hours/Times p/w or relevant time or if refused services						

SERVICE (Tick)	PHN/CMHN ☐	Family support/ Private Carer ☐	Therapy or other discipline ☐	Day Hospital ☐	Services Refused ☐
Hours/Times p/w or relevant time or if refused services					

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

6(a). CURRENT DIAGNOSIS AND MEDICAL SUMMARY:

(Please include only relevant conditions)

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

6(b). DETAILS OF THE PERSON'S MENTAL HEALTH STATUS:

(Please attach any supporting documentation, if available)

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

7. CURRENT MEDICATIONS (See Guidance Notes - Not for Purpose of Dispensing)

Name of Drug	Dosage	Frequency	Name of Drug	Dosage	Frequency

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

8: ASSESSMENTS

8 (A): BARTHEL INDEX

WEIGHTING SCORE	3	2	1	0	DATE SCORE	DATE SCORE
				Please insert Date(s) Undertaken		
Bowel (Preceding week)		Continent	Occasional Accident	Incontinent (Or needs an enema)		
Bladder (Preceding 24-48 hours)		Continent	Occasional Accident	Incontinent (Or Catheterised & Unable to Manage)		
Grooming			Independent	Needs Help		
Toilet Use		Independent	Needs Some Help	Dependent		
Feeding		Independent	Needs Some Help	Unable		
Transfer (From bed to chair & back)	Independent	Minimal Help Needed	Major Help (1-2 persons) Needed	Unable (No sitting balance)		
Mobility	Independent	Walks with help of 1 person	Wheelchair Iindependent	Immobile		
Dressing		Independent (Buttons, zips and laces)	Needs Help (But can do half unaided)	Dependent		
Stairs		Independent (Up & down must carry walking aid)	Needs Help (Verbal or physical/carrying of aid)	Unable		
Bathing			Independent (Getting in & out unaided & wash self)	Dependent		
Findings	Independent (20)	Low Dependency (16-19)	Medium Dependency (11-15)	High Dependency (6-10)	Maximum Dependency (0-5)	**TOTAL**

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

8 (B): COMMUNICATION

	Tick	Date	Signature
No problems	☐		
Retains most information and can indicate needs verbally	☐		
Difficulty speaking but retains information and indicates needs non-verbally	☐		
Can speak but cannot indicate needs or retain information	☐		
No effective means of communication	☐		

8 (C): COGNITIVE SCREENING REPORT - BY DATE ORDER IF MORE THEN ONE AVAILABLE

Cognitive Assessment (Specify Screening Tool)	Date	Result	Signature	Date	Result	Signature

8 (D): OTHER ASSESSMENTS (Specify Tool Used)

	Result	Date	Signature
Pressure Sore Risk			
Falls Risk			
Nutritional Risk			
Wandering Risk			
Other - Specify			

8 (E): OTHER SIGNIFICANT MEDICAL/SOCIAL/ RISK FACTORS THAT SHOULD BE CONSIDERED AS PART OF THE CARE NEEDS ASSESSMENT:

Completed by: NAME: _____ Role: _____ Date: _____ Signature: _____
(PRINT)

9: ADDITIONAL COMMENTS e.g. Employment, Recreational or Social Needs (Attach supporting documentation):

Completed by: NAME: _____ (PRINT) Role: _____ Date: _____ Signature: _____

10(a). HEALTH PROFESSIONAL REPORTS.

(Please attach if relevant. Tick to indicate a report is appended)

Nursing ☐	Dietician ☐	Occupational Therapy ☐	Speech and Language ☐	Other ☐
Physiotherapy ☐	Psychology ☐	Podiatry ☐	Social Work ☐	

10(b). SPECIALIST ASSESSMENT

(Best practice recommends that all older people should have a Consultant Geriatrician/Old Age Psychiatry assessment prior to a decision being made about their future care needs.)

Geriatric Medicine	Completed		Date:		**Signature:**	
Old Age Psychiatry	Completed		Date:		**Signature:**	
Rehabilitation Consultant	Completed		Date:		**Signature:**	
Neurologist	Completed		Date:		**Signature:**	
Other(Specify)	Completed		Date:		**Signature:**	
Specialist Comment: (Or append report)						

Completed by: NAME: _____ (PRINT) Specialty: _____ Date: _____ Signature: _____

11. RECOMMENDATION BY MDT. For Completion by MDT. See Guidance Notes

It is the recommendation of this MDT that this person's overall care needs are currently best met within a Long Term Residential Care Setting (Please Tick):

Yes ☐ **No** ☐

Confirmation of MDT's Recommendation	**Confirmation of MDT's Recommendation**
Name: _____	Name: _____
Role: _____ Date: _____	Role: _____ Date: _____
Signature: _____	Signature: _____

Name & Signature of Professional Co-ordinating completion of this CSAR Form

NAME: _____ (PRINT) Role: _____ Date: _____ Signature: _____

12. LPF DETERMINATION OF CARE NEEDS FOR COMPLETION BY LPF ONLY

It is **the determination** of this LPF that this person's overall care needs are currently best met by:

	(Please Tick)	Additional Information
Long Term Residential Care Setting	☐	
Sheltered Housing	☐	
Other (Specify)	☐	
At Home with Community Supports	☐	
Likelihood of change in personal circumstances		Low Risk ☐ Medium Risk ☐ High Risk ☐

Confirmation of LPF's Determination	**Confirmation of LPF's Determination**	**Confirmation of LPF's Determination**
Name: _____	Name: _____	Name: _____
Role: _____ Date: _____	Role: _____ Date: _____	Role: _____ Date: _____
Signature: _____	Signature: _____	Signature: _____

IF LONG TERM CARE IS NOT DETERMINED TO BE APPROPRIATE-THE FOLLOWING SERVICE(S) ARE RECOMMENDED BY LPF

Service Recommended	Home Help/Support ☐	Day Care ☐	Respite ☐	Meals Supply ☐	Laundry ☐	Aids/ Appliances ☐
	PHN/CMHN ☐	Therapy or other discipline ☐	Day Hospital ☐	Other (Specify) ☐	Other (Specify) ☐	
Comment(s)						