



Western Isles

**Community Health and
Social Care Partnership**



CARER'S ASSESSMENT

ABOUT YOU	
Name Preferred Name	
Address	
Telephone No.	
Date of Birth	
Your G.P. Address	Telephone Number
Is your G.P. aware that you are a Carer? Yes/No	
What is your relationship to the person or people you look after?	
Do you look after more than one person?	Yes/No/How Many
Please give the name(s) of the people you look after (see page 7).	
I do/do not give permission for the details given on this form to be incorporated in the Register of Carers held by the Western Isles Community Care Forum	
Signed	

YOUR CIRCUMSTANCES

What help do you give the person/people you look after, please give details of how often you provide this help (you might find it helpful to complete the form on page 7)

Do you or they receive any help from home care services (social work), the voluntary sector, Crossroads, Cobhair Bharraigh (Barra), Tagsa Uibhist (Uist) etc?

Do you receive any help at the moment from any other family members, friends or professionals?

Are you satisfied with the current services and help you receive? If no what extra help do you need?

YOUR HEALTH AND WELL BEING

Have you had any physical injuries or strains as a result of moving the person you care for or whilst handling any equipment used whilst caring?

Do you ever feel tired or stressed? – How often?

What extra assistance would help?

Does your own health affect your ability to look after others? Yes/No
If yes, please provide details, including details of what can be done to address this.

Are there any particular things that you find more difficult? If yes, please give details.

Does your caring role impact on your family relationships? If yes, please give details

FINANCE

Has there been an impact on your finances as a result of your caring role?
Are you aware of your benefit entitlement?
Would you like to be contacted by a member of the Council's 'Claim It' Team to discuss your entitlements.

Would you like advice on handling legal/financial matters for the person(people) you look after (becoming an appointee/legal guardian/financial guardian/getting power of attorney?)

EMPLOYMENT

Are your caring responsibilities affecting your ability to retain your employment? If yes, please give details.

Would you be interested in finding out more about employment/educational/leisure opportunities?

YOUR ROLE AS A CARER

Do you feel you are confident in your role as a carer?
Do you feel able to manage your caring role, or would you like more help?
What kind of help would be useful? (Would you like any training to help you meet the demands of your caring role ie moving and handling training, medication management, infection control etc).

Is the person/people you look after able to be left alone?

For short periods (less than half an hour)?

For longer periods (approx. two hours – e.g. shopping trip)?

Does the person/people you look after have any concerns about being able to cope on their own when you are not around?
Are you able to pursue leisure/educational activities or opportunities that you enjoy?

Do you have some-one who can step in and replace you for short periods of time to allow you a few hours to pursue your own interests Yes/No

Would you welcome help from such a person Yes/No

ACCESS TO INFORMATION

Do you feel you have been given sufficient information to enable you to provide care?
Would you like to have a discussion with a Health Care Professional/Social Worker/a voluntary caring organisation?

LOOKING TO THE FUTURE

Are there any potential changes in the future that may affect your ability to continue in your caring role?
If yes, what are these?

What can be done to address this?

EMERGENCY CONTACT(S) IF YOU ARE NOT AVAILABLE OR BECOME ILL (IF CARED FOR NOT ON FAIRE ALARM SYSTEM)

Name (who should we contact)	Address
Tel No.	Relationship to cared for person/people.
Name (who should we contact)	Address
Tel No.	Relationship to cared for person/people.

Please give name(s) and relationship(s) to each person you care for, number 1 being the person who receives the most help from you and so on.

ABOUT THE PERSON/PEOPLE YOU LOOK AFTER			
Their Name (Person 1)			
Their Address			
Telephone No.		Date of Birth	
Their GP			
Are you the main carer for this person? <input type="checkbox"/>			
Has he/she had an assessment of their needs? If yes, please provide details of their assessor, date of assessment. If no is there any particular reason for this?			
Are you satisfied with your involvement in the design of this person care YES/NO If no, please give details.			
Their Name (2 nd Person)			
Their Address			
Telephone No.		Date of Birth	
Their GP			
Are you the main carer for this person? <input type="checkbox"/>			
Has he/she had an assessment of their needs? If yes, please provide details of their assessor, date of assessment. If no is there any particular reason for this?			
Are you satisfied with your involvement in the design of this person care YES/NO If no, please give details.			

Caring Responsibilities - Tasks undertaken for those cared for

Care that is required	Person Giving Help	Frequency			Daily	Weekly	Monthly
		Day	Evening	Over Night			
Getting out of Bed							
Getting into Bed							
Washing							
Bathing/Showering							
Other Personal Hygiene							
Shaving/Grooming							
Emptying Commode							
Dressing							
Help to use the Toilet							
Making Drinks							
Preparing Meals							
Feeding							
Dealing with Incontinence							
Medication & Medical Procedures							
Motivation/Stimulation							
Laundry							
Cleaning							
Shopping							
Dealing with Correspondence							
Emotional Support							
Communication							
Business Matters (eg paying bills, collecting Pension)							
Maintaining Garden & Property							
Behavioural Issues please detail							
Transport							
Going Out							

Name and agency of Assessor/ Point of Contact		CARER'S CONSENT TO SHARE WITH Other Agencies Cared for Person		
DATE:	Carer's Assessed Need	Identified actions and agreements e.g. the support services/activities/resources that are required	REVIEW DATE	SIGN
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-