Date of Request for this form: _____ Case No.: _____

Name: _____ IMM. No.: _____

ACTIVITIES OF DAILY LIVING (ADL)

1. Self-care	Intact (1) *	Limited (2) *	Helper (3) *	Unable (4) *
	(Note performance without help)		*(Note degree of assistance)*	
	With ease, no devices, no prior preparation	With difficulty, or with device, or prior preparation	Some help	Totally dependent
Preparing a meal	£	£	£	£
Feeding / Drinking	£	£	£	£
Managing medication	£	£	£	£
Dress Upper Body	£	£	£	£
Dress Lower Body	£	£	£	£
Don Braces/Prosthesis	£	£	£	£
Grooming	£	£	£	£
Wash / Bathe	£	£	£	£
Cleaning perineum (at toilet)	£	£	£	£

2. Sphincters Control	Complete	Complete with Urgency	Occasional Accidents	Frequent Accidents
	(Note control without help)		*(Note frequency of accidents)*	
	Complete, voluntary	Control, but with urgency, or use of catheter, appliance.	Occasionally some help needed.	Frequent or often wet/soiled
Bladder Control	£	£	£	£
Bowel Control	£	£	£	£

3. Mobility/ Locomotion	Intact (1) *	Limited (2) *	Helper (3) *	Unable (4) *
	(Note performance without help)		**(Note degree of assitance)**	
	With ease, no devices, no prior preparation	With difficulty, or with device, or prior preparation	Some help needed	Totally dependent
Able to stand	£	£	£	£
Transfer to bed/ chair/ wheelchair /toilet	£	£	£	£
Transfer to bath/ shower	£	£	£	£
Transfer to car	£	£	£	£
Walk 50 metres - Level	£	£	£	£
Stairs, Up/Down 1 Floor	£	£	£	£
Walk 50 metres (indoors or outdoors)	£	£	£	£
Cognitive/ mental capacity to go outdoors	£	£	£	£
Wheelchair 50 metres	£	£	£	£

4. Communication/ Engaging with other people.	Intact	Limited	Helper	Unable
Expression / speaking	£	£	£	£
Social Cognition	£	£	£	£
Social Interaction	£	£	£	£
Memory	£	£	£	£
Ability to learn/ mental capacity	£	£	£	£
Visual capacity	£	£	£	£
Hearing	£	£	£	£

To be completed for children aged under 16 only:
Based on the child's disability or health condition, what additional needs does this child have compared to an avarage child of the same age?

Current Residence

£ Own Home £ Relative's Home £ Other's (Specify) _____

£ Personal Care Home £ Hospital

Current Care Giver

Name (Firstname LastName) _____

Relationship to Patient _____ Assistance to continue post arrival £ Yes £ No

Remarks