Section 1		
PIN Number	**SAP Number**	
Name		
Date Of Birth		
Address		
Tel No		
GP Details	**Tel No**	
Nurse Details	**Tel No**	
Others present at the assessment		
Name	**Relationship**	
Name	**Relationship**	
Name	**Relationship**	
Name	**Relationship**	
Next Of Kin		
Name		
Emergency Contact?	**Yes**	**No**
Address		
Relationship		
Telephone Number		

Other Significant Contacts		
▪ **1** **Name**		
Emergency Contact?	**Yes**	**No**
Address		
▪ **2** **Name**		
Emergency Contact?	**Yes**	**No**
Address		
▪ **3** **Name**		
Emergency Contact?	**Yes**	**No**
Address		
▪ **4** **Name**		
Emergency Contact?	**Yes**	**No**
Address		

Section 2

Mental Capacity - Consent to Assessment

Definition and test of incapacity

'A person must be assumed to have capacity unless it is established that they lack capacity'.

Is there an impairment of, or disturbance in, the functioning of a persons mind or brain? Can the person;-

- Understand the information relevant to that decision?
- Retain the information?
- Use or weigh that information as part of the process of making the decision?
- Communicate their decision?

This is not determining consent to the support plan only the service users participation in this assessment.

Are there any issues in relation to the person's mental capacity that may affect their ability to take part or consent to this assessment taking place?

	Yes	**No**	

If yes, please detail here ..

If no go to section 3

If yes, does a formal capacity assessment need to take place?

	Yes	**No**	

If yes, this is to be instigated by the assessor.

If no, is it in the person's best interest for this assessment to take place?

	Yes	**No**	

If yes, then the assessment should proceed involving the person as much as possible.

If no, discuss with your line manager.

Mental Capacity - Consent to Assessment (continued)

Are there reasons to believe that the person may lack the capacity to consent to any support plan that may result from this assessment?

	Yes	No	

If yes, follow the Directorate's practice guidelines for Best Interest assessment prior to the development of any support plan.

Section 3

Safeguard and Protect

Dudley MBC want to ensure all citizens of Dudley feel safe and secure in their environment and feel secure with the people they may come into contact with.

Do you feel safe and secure in your own environment and with the people you come into contact with?

	Yes	No	

If no, please give details here ..

Section 4

Details of existing support provision

This is to include details of any current support provision formal/informal. Is the service user reliant on anyone to help them cope with every day living? Any previous contact with social services?

Section 5

Details of background and current circumstances

This is to include details of (where appropriate) housing, finances, physical and mental health, cultural needs, diet, interest etc. To include reasons for this recent contact.

Section 6

Service User's View

This is to include details of the views of the service user.

Section 7

Carers View

This is to include details of the views of the primary carer.

Is a Carers Assessment Required?	**Yes**	**No**

Section 8

Views of other people contributing to this assessment.

This is to include details of the views/comments of other people who contributed to this assessment. This may include a district Nurse, Doctor, friend or neighbour or from College/Work placements.

Section 9

Identified Hazards.

This is to include details of hazards in relation to the environment, personal safety and task .

Environmental

Task Related

Personal Safety

Section 10

Maximising Independence

Every person being assessed will be considered for options to help maximise their independence, prior to considering long term care/support.

Detail the measures to be taken to improve/maintain independence for this person.

Section 11

Progress to Part 2

If the assessment ends here, then complete the closing summary of actions and reasons for non progress to RAS, before submitting the assessment to your locality Team Manager.

If the assessment requires completion of Part 2, then completed copies of Part 1 and Part 2 should be submitted together, to your Locality Team Manager for approval.

Worker Name	
Worker PIN	
Date	

Section 12

Discharge Details - *Hospital Social Work Teams Only*

Date of Discharge	Anticipated date of transfer	District

Section 13			
This section to be completed only if Residential / Nursing resource is required OPPD staff only			
Date of request to Panel			
Dates of last Panel applications made			
Client currently in	Community	Hospital	Bushey Fields
If in hospital	Date of admission	Ward	
Resource Request			
Care Home Category			
Consideration to extra Sheltered Care			
Consideration Rehabilitation			
Degree of Risk			
Multi Disciplinary Assessment			
Has Continuing Health Care (CHC) Assessment been completed?	**Yes**	**No**	
If Yes, Date CHC Assessment completed? Outcome of CHC Assessment If No, Is one being planned?			
For existing residents - Length of time resident			
Key criteria			
Breakdown & Cost of Contingency			
Preferred area of placement			
Team Managers Comments			
Team Manager	Date		

Section 14				
Adult Social Care Data Collection Sheet				
Client referred to Dudley MBC : Directorate of Adult, Community and Housing Services Use Only				
Name			PIN	
This Assessment resulting from:				
(a) Contact [ ]	(b) Referral [ ]	(c) Assessment [ ]	(d) Review [ ]	Date
Assessment Start Date		Assessment End Date		
Reason for Delay				

Place of Assessment	Community/Hospital	Residential	Nursing
Type of Assessment	Joint with Carer Yes / No	Multidisciplinary Yes / No	Direct Payment Offered Yes / No / Not Appropriate
List Multi-disciplinary Involvements			

Needs Identified				
Accommodation ☐	Carer Support ☐	Communication ☐	Cultural Issues ☐	Disease Prevention ☐
Education ☐	Employment ☐	Ensure Safety ☐	Financial ☐	Health Care ☐
Home Management ☐	Housework ☐	Information ☐	Mobility Problems ☐	Personal Care ☐
Professional Support ☐	Regular Supervision ☐	Rehabilitation ☐	Risk Assess ☐	Social Interaction ☐
Special Assessment ☐	Substance misuse ☐	Transport ☐		

Others involved with service user – Please ensure they are indicated on SAP9a & SAP9b and listed

Carers Name	Offered Individual Carers Assess	Individual Carers Assess accepted	Joint assessment with client	Declined to be involved in joint assessment
	Yes / No	Yes / No	Yes / No	Yes / No
	Yes / No	Yes / No	Yes / No	Yes / No
	Yes / No	Yes / No	Yes / No	Yes / No

Copy of care plan to service user	Yes / No	More information requested by carer	Yes / No
Copy of care plan to carer(s) at Joint assessment	Yes / No	Refer to carers register	Yes / No

Reason for Care Plan non issue	
Team Manager Signature	
Outcome of Assessment	
Assessment Completed by	
Worker Name	
Worker PIN	
Date	