



**Portland
College**

Initial Assessment Document Personal and Healthcare Needs

(Information supplied by prospective learner/parent/guardian)

Learner Name:

Name of person completing form:
(Please state your relationship)

Place required from:

Residential:

Non-Residential:

[Please return to:](#)

**Recruitment Assessment Team
Portland College
Nottingham Road
Mansfield
Notts
NG18 4TJ**

**Tel: 01623 499185
Fax: 01623 499134**

Contact Details

Contact Information:

Learner name:.....

Preferred to be known as:

Date of Birth:

Address:

.....

Post Code:.....

Telephone No:

Alternative No:

GP Contact:

Doctors Name:

Address:

.....

Post Code:.....

Telephone Number:

Next of Kin:

Name:

Address:

.....

.....

Post Code:.....

Telephone Number:

Mobile Telephone Number:

Religious/cultural needs

Please indicate details of any specific personal needs.

.....

.....

.....

Medical Exemption number

National Insurance number

Medical information

Diagnosis:

.....

Medication Prescribed:	How is this taken?		
	Orally	Rectally	Self -medicated
1.			
2.			
3.			
4.			
5.			

Allergies/Drug Sensitivity (e.g. foods, pollen, animals or latex)

1.....

2.....

3.....

Operations

Previous Operations: Date.....

Previous Operations Date.....

Previous Operations Date.....

Planned Operations..... Date.....

Planned Operations..... Date.....

Planned Operations..... Date.....

Therapists

Physiotherapy:

Occupational:

Speech & Language:

Psychologist:

Other:

Consultants Names and Addresses

Orthopaedic.....

.....

Neurological

.....

Paediatrics

.....

Other

.....

Medical History

Do you have a history of any of the following?
Please give relevant information in spaces provided
Please indicate in boxes YES or NO

Epilepsy:

How often do you have a seizure?

How long do the seizures last?

What intervention do you require?

Do you recognise when you are going to have a seizure?
If so **please specify:**

.....

Diabetes:

Heart Problems:

Mental Health Problems:

Depression/Anxiety:

Asthma:

High Blood Pressure:

Eating Disorders:
(Anorexia/Bulimia)

Breathing Difficulties:
(E.g. Tracheotomy – Oxygen – Restriction – Repeated Chest Infections)

Please provide **FULL DETAILS:**
.....
.....

Others:
(E.g. Botox – Spinal Rods – Tendon Releases – Hip Displacements etc)

Please provide **FULL DETAILS:**
.....
.....

Additional Information (including any further relevant medical/therapy involvement)
Please include any relevant contact details:
.....
.....
.....

Vaccinations

Indicate in Boxes YES or NO

	Vaccination	Dates		Vaccination	Dates
	Tetanus			Meningitis	
	Diphtheria			MMR	
	Polio			TB	
	Hep B			Other:	

Remarks:

.....

Pain

If you have pain on a regular basis please supply us with some information:

Where:

.....

How often:

.....

What word would you use to describe it?

(E.g. Ache, toothache, sharp, stabbing or dull).

.....

How do you relieve this?

(E.g. Pain relief, tens machine, postural manage, alternative therapies).

.....

On a scale of 0 – 10, 0 being no pain and 10 being pain that makes you cry.

Please mark on the line below pain:

At its best:

0----1----2----3----4----5----6----7----8----9----10

At its worst:

0----1----2----3----4----5----6----7----8----9----10

Any other comments in respect of pain please complete below:

.....

Skin

How would you describe what type of skin you have: e.g. dry, oily, scaly, broken etc.

.....
.....

Do you have or have you ever had Eczema? **Yes No**
(Please circle appropriate answer)

If yes please provide details:

Where:.....
.....

Treatment used:

.....
.....

Do you have or have you ever had pressure sores? **Yes No**
(Please circle appropriate answer)

If yes please provide details:

Where:.....
.....

Treatment used

:.....
.....

Do you consider yourself at risk of getting sore in any area of your body?
(Please circle appropriate answer) **Yes No**

If yes please provide details:

.....
.....
.....
.....

Do you use any pressure relieving equipment e.g. special mattress or cushion?
(Please circle appropriate answer) **Yes No**

If yes please provide details:

.....
.....
.....
.....

Do you see a district nurse for any reason? **Yes No**
(Please circle appropriate answer)

If yes please provide details:

.....
.....
.....
.....

Eating and Drinking

Diet:

Do you have any special dietary needs e.g. vegetarian, halal, diabetic, soft or liquidised, thickened etc?
(Please circle appropriate answer) **Yes** **No**

If yes please provide details:

.....
.....
.....
.....

Chewing and swallowing:

Do you have or have you ever had any problems with chewing or swallowing?
(Please circle appropriate answer) **Yes** **No**

If yes please provide details:

.....
.....
.....
.....

Do you require any changes to ordinary food textures and fluids (e.g. all foods blended, food to be moist and finely chopped, fluids thickened to a single cream consistency etc).? Please give details.

.....
.....
.....
.....

Do you require any specific utensils for eating and drinking (e.g. special cups, size of cutlery used)?
Please give details/names of utensils etc.

.....
.....
.....

Please give a brief description of how you like carers to support you with eating and drinking (e.g. whether they should be at your right or left side, the pace at which you like to be given food, whether you like a drink between mouthfuls of food etc)

.....
.....
.....
.....

What is the best position for you to be in when eating and drinking (e.g. in manual wheelchair with head rest on, facing away from distraction in the room)?

.....
.....
.....
.....
.....

Equipment or Assistance

Do you need any special aids or assistance to help you eating or drinking?

(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....
.....
.....

Teeth and gums

Do you have false teeth?

(Please circle appropriate answer)

Yes No

Do you suffer from sore gums?

(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

Weight:

Have you had any recent weight loss or gain?

(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

What is your current weight?

.....

Communication Skills

Do you have any problems understanding others speech?

(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....
.....
.....

How would you describe your ability to get on with others e.g. shy, easy going etc?

.....
.....

How do you express yourself?

	Please give details
Speech	
Signing/nonverbally (*Also see below)	
Communication aid	

Have you seen a speech and language therapist?

(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....
.....
.....

*If you have difficulty telling us about yourself, please help us by answering the questions below and bringing with you any communication aids or books, labelled family photos and **ANY** other information/pictures you have at home.

Details of

family/friends/pets.....

.....
.....
.....
.....
.....

Particular

likes/dislikes.....

.....
.....
.....
.....
.....

How do you communicate your basic needs/wants?

E.g. yes/no, I want, help me, go away, and stay with me

.....
.....
.....
.....

How do you tell us when you are feeling: thirsty/hungry/tired/happy/angry/in pain?

.....
.....
.....
.....

Memory

What is your memory like e.g. short-term memory loss etc?

Please provide details:

.....
.....
.....

Hearing

Do you have hearing problems?
(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

Do you need any aids to help you hear?
(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

Vision

Do you wear glasses?
If so when do you need to wear them?

.....
.....

Do you have any other visual difficulties?

(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

Moving- Handling and mobility

Mobility

How do you get around inside and out e.g. Wheelchairs, crutches and walking frames?

Please provide details:

.....
.....

Do you need any help to get around i.e. pushing of wheelchairs, supervision of walking/driving etc?

Please provide details:

.....
.....

Transfers:

How do you transfer from chair to bed?

Please provide details:

.....
.....

Do you need any equipment to help your transfer?

Please provide details:

.....
.....

Do you need any help to use this equipment?

Please provide details:

.....
.....

Sleeping

Do you have a sleeping routine e.g. Rest periods during the day, times to go to bed and when you get up?

(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

Do you like to be positioned in a special way to help you sleep?

(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

Do you have any special equipment i.e. Bedrails, pressure relieving mattress system, special bed?

(Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

Are you able to use a call alarm system?

(Please circle appropriate answer)

Yes No

What do you use at home?

.....
.....

Do you need turning at night?

(Please circle appropriate answer)

Yes No

Do you need to have early nights?

(Please circle appropriate answer)

Yes No

Are you able to direct your care needs?

Please circle appropriate answer)

Yes No

(Remember you will be expected to attend your normal timetable Mon – Fri)

Dressing and Undressing

Are you able to fully dress and undress yourself?

Please circle appropriate answer)

Yes No

Are you able to make appropriate choices about what to wear?

Please circle appropriate answer)

Yes No

Do you know when your clothes need changing?

Please circle appropriate answer)

Yes No

If you need assistance are you able to direct your carers?

Please circle appropriate answer)

Yes No

Do you need any equipment or adaptations to aid you with your dressing?

Please circle appropriate answer)

Yes No

How many carers are required to help you dress?

Please State:

Do you wear make-up?

Please circle appropriate answer)

Yes No

Do you need help putting it on?

Please circle appropriate answer)

Yes No

Toileting

Do you require any assistance when going to the toilet?

Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

If full assistance is required – are you able to direct?

Please circle appropriate answer)

Yes No

Do you have difficulty passing urine e.g. wear pad and pants, catheter (if so how often do you need catheterising), wear convene etc

Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

Do you have difficulty opening your bowels e.g. do suffer from constipation, loose stools

Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

What help do you need to help you go to the toilet e.g. Suppositories, medication or enema?

.....

Are any aids required e.g. Chair/urine bottles – please state

Please circle appropriate answer)

Yes No

If yes please provide details:

.....
.....

If no assistance is required are you able to clean yourself effectively?

Please circle appropriate answer)

Yes No

Do you have periods?

Please circle appropriate answer)

Yes No

If YES please tell how often and please tell us any other information that we need to know to help you

.....
.....

Are you aware of the importance of hand washing after using the toilet?

Please circle appropriate answer)

Yes No

Hygiene

Are you able to wash your hands and face?

Please circle appropriate answer)

Yes No

Are you able to clean your teeth?

Please circle appropriate answer)

Yes No

Are you able to shower /bath yourself?

Please circle appropriate answer)

Yes No

If no what help do you need?

.....
.....

Equipment

Please indicate if you use equipment to help you manage with your Activities of Daily Living. Please indicate what equipment you use at home and at school, providing the **model** and **size** where possible. If you use different pieces of equipment at home and at school please indicate which one you prefer. Also please let us know if the equipment requires replacing.

Activity	Equipment at home	Equipment at school
Toileting - eg type of toilet chair etc		
Showering – eg type of chair (this may be also used for toileting)		
Bathing - eg bathboard, bathbed etc		
Eating - eg special cutlery, neater eater etc		
Sleeping - eg sleep system, bedsides etc		
Mobility - eg powered wheelchair, manual wheelchair etc		
Transfers – eg hoist and slings used, transfer board etc		

It is your responsibility to bring your personal care equipment with you when you come to Portland College, particularly if it is specialised. Portland College does not fund this equipment - this is the responsibility of your local Social Services. **If you have any questions or concerns please contact Sheena Hardwick Occupational Therapist at Portland College - 01623 499111 x 267 or email shardwick@portland.ac.**

Data Protection Declaration

“Data Protection Act 1998 – The information you provide on this form will be passed to the Learning and Skills Council (the LSC). The LSC is responsible for funding and planning education and training for over 16-year-olds in England, and is registered under the Data Protection Act 1998. The information you provide will be shared with other organisations for the purpose of administration, careers and other guidance, and statistical and research purposes. Other organisations with which we will share information include, the Department for Education and Skills, Connexions, Higher Education Statistics Agency, Higher Education Funding Council for England, educational institutions and organisations performing research and statistical work on behalf of the LSC or its partners. The LSC is also a co-financing organisation and uses European Social Funds from the European Union to directly or indirectly part-finance learning activities, helping develop employment by promoting employability, business spirit and equal opportunities, and investing in human resources. Further information about partner organisations and what they do, may be found at <http://www.lsc.gov.uk>, and by following the links to data protection.

Please tick

WHITE <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other British	MIXED <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Other Mixed
ASIAN OR ASIAN BRITISH <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Other Asian	BLACK OR BLACK BRITISH <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other Black
CHINESE OR OTHER ETHNIC GROUP <input type="checkbox"/> Chinese <input type="checkbox"/> Other Ethnic Group	

At no time will your personal information be passed to organisations for marketing or sales purposes. From time to time students are approached to take part in surveys by mail and phone, which are aimed at enabling the LSC and its partners to monitor performance, improve quality and plan future provision. “

Signed:	Status:
Date:	