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 <u>must be sought and recorded.</u>

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)

CSAR Applicant's Name ________________________________ DOB ______________

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)

CSAR Applicant's Name ______________________________ DOB ______________

8: ASSESSMENTS

8 (A): BARTHEL INDEX

8 (A): BARTHEL INDEX				Please insert Date(s) Undertaken	DATE	DATE
WEIGHTING SCORE	**3**	**2**	**1**	**0**	**SCORE**	**SCORE**
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: ______________________ Role: ____________ Date: ________ Signature: ____________
(PRINT)

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: ______________________ Specialty: ____________ Date: ________ Signature: ____________
(PRINT)

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: ______________________ Role: ____________ Date: ________ Signature: ____________
(PRINT)

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)						