

**OCCUPATIONAL THERAPY DEPARTMENT
HOME ASSESSMENT REPORT**

Name:		D.O.B:		People Present:
		Date of Visit:		
Address:		Consultant:		
		G.P:		
		Diagnosis:		
Postcode:				
Phone No:				

HOME CIRCUMSTANCES

SUPPORT SERVICES

ACCESS

MOBILITY

STAIRS

TRANSFERS:-

- CHAIR
- BED
- TOILET
- COMMODE
- BATH

FALLS
Have you fallen recently? Yes/No
If so:

- place of fall
- cause of fall
- time of fall
- activity of fall
- frequency of falls
- equipment involved
- fear of future falls

**PERSONAL
ACTIVITIES OF
DAILY LIVING**

- Feeding
- Toileting
- Washing
- Dressing
- Bathing
- Shaving

**DOMESTIC
ACTIVITIES OF
LIVING**

- Laundry
- Shopping
- Housework
- Meal Prep.
- Hot Drink

HEATING		
PSYCHOLOGICAL FACTORS		
CARERS / RELATIVES		
RECOMMENDATIONS		ACTION
CONCLUSION		
THERAPIST'S NAME		Contact Tel:
LOCATION		
Therapist's Signature		DATE