

# Thurrock Council

## Self-assessment for equipment and minor adaptations

### Section 1 – personal details – you must complete this section

Title	<input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Other: _____		
Forename(s)			
Surname			
Height		Weight	
Address, including postcode			
Date of birth			
Preferred phone number		Other phone number	
Email address			
Next of kin name			
Next of kin relationship			
Next of kin phone number			
GP name			
GP phone number			
GP address, including postcode			

### Section 2 – home and household details – you must complete this section

Type of accommodation	<input type="checkbox"/> House <input type="checkbox"/> Flat – specify level: _____ <input type="checkbox"/> Bungalow <input type="checkbox"/> Other – specify: _____
Property type	<input type="checkbox"/> Home owner <input type="checkbox"/> Thurrock Council <input type="checkbox"/> Private landlord – please give details below <input type="checkbox"/> Housing Association – please give details below <input type="checkbox"/> Other – please give details below
Owner's details – name, address, phone number	
Do you live alone	<input type="checkbox"/> Yes <input type="checkbox"/> No – please give details below
Household details – name, relationship, age of people living with you	

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### Section 3 – about your general health – you must complete this section


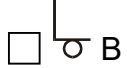
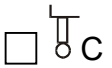

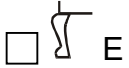
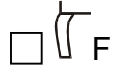
Do you have any ongoing medical conditions or chronic / life limiting illnesses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty doing things because of injury, pain and / or weakness in one or both of your arms / your legs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any difficulty with your memory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you answered 'Yes' to any of the above, please give brief details below. We would like to know about your medical conditions / illness / disabilities, how they cause you difficulty with everyday tasks, and how long you have had these difficulties.		
Have you been in hospital in the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 'Yes', please tell us which hospital you went to, why you were there, what treatment you received or expect to receive and the date you returned home?		
Have you had any falls in the last 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 'Yes', please tell us where and why?		
Did the fall result you going to hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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## Self-assessment for equipment and minor adaptations

### Section 6 – getting on and off your bed

We may be able to give you a bed rail or raise your bed so it is easier to get in and out of it.

Do you think it would help to have a bed rail on your bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you think it would help to raise your bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What type of bed do you have?	<input type="checkbox"/> Single <input type="checkbox"/> Double <input type="checkbox"/> Divan, with drawers <input type="checkbox"/> Divan, without drawers <input type="checkbox"/> Wooden, slatted <input type="checkbox"/> Metal, slatted <input type="checkbox"/> Electric We may not be able to raise or provide bed rails for an electric bed. <input type="checkbox"/> Other – details:
What type of legs / feet does your chair have? Either select an image or describe below.	
<input type="checkbox"/>  A <input type="checkbox"/>  B <input type="checkbox"/>  C <input type="checkbox"/>  D <input type="checkbox"/>  E <input type="checkbox"/>  F or describe: _____	
How many legs does your chair have?	
Please tell us the height you would like to raise your bed – state whether in inches or centimetres and refer to section 1a of the guidance	

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## Self-assessment for equipment and minor adaptations

### Section 12 – other information or comments

Please provide any other information or comments you feel would be beneficial

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## Self-assessment for equipment and minor adaptations

### Section 13 – signing the form – you must complete this section

I have read the guidance available and the information I have given is an honest view of my situation, true to the best of my knowledge. I understand I will be provided equipment and / or minor adaptations based on the information I have provided and accept responsibility for incidents resulting from inaccurate information I may have given.

Name			
Signature		Date	

Has someone helped you to complete this form?  No  Yes – please give details below.

Name of person who has helped you			
Relationship to you			
Signature		Phone	
Reason why you asked for help in completing the form			
Do they have lasting power of attorney for your health and welfare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

### Consent to contact your GP or other health professional

It may be necessary for us to contact your GP or other health professional – for example, a nurse or physiotherapist – to better understand your difficulties and support your request. Please provide the name, address and contact details of any other health professional you think would be able to help your request.

Name			
Address			
Phone number			
Name			
Address			
Phone number			

I give my consent for information to be shared about me

Name			
Signature		Date	

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### Section 14 – sharing information agreement – you must complete this section

In order to fully understand your situation, it will be essential to discuss with some other agencies and people what they know about you. We will only ask them about matters that concern your health and care needs. This could include your financial circumstances if this is affecting you or your family's wellbeing. It may also be necessary to share with them information we have about you – we need your permission to do so.

The following are the agencies and people who generally are able to help. By completing and signing this form you agree to us using and sharing your information in this way, including the collection of your NHS number to help us provide efficient and targeted services to you.

- social services departments
- general practitioner
- hospital staff
- nursing staff
- community health staff
- friends/relatives
- housing department
- benefits agency
- others as relevant to your care

Is there anyone you specifically do not want us to share your information with?	
Is there any particular information you do not want us to share with anyone?	

We may need to share information about you without your prior consent in certain circumstances, such as in an emergency to protect your health and safety, or to assist the police with crime prevention. We will only share information without your consent when the law allows us to.

If you would like to change the permissions you have given us here, you must contact us so that we can update our records. We will discuss this again with you at your next review.

Name			
Signature		Date	

Person acting on behalf of service user, if applicable	
What authority do you have?	
Address, including post code	

### Office use only

<input type="checkbox"/> Information regarding access to client files given		
<input type="checkbox"/> Information regarding complaints procedures given	Date	
Officer name, completing form with service user		
Officer job title		

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### Section 15 – equalities monitoring – you must complete this section

Equalities monitoring helps us to understand how different sections of the community use our services. We collect this information solely for counting statistics, so we can check for inequalities and take action where it's needed. If you would rather not answer these questions, please select 'prefer not to say'.

#### Gender – are you:

- female
- male
- gender neutral
- transgender
- prefer not to say
- other: \_\_\_\_\_

#### Age – are you:

- 17 years-old or under
- 18 to 24 years-old
- 25 to 34 years-old
- 35 to 44 years-old
- 45 to 59 years-old
- over 60 years-old
- prefer not to say

#### Ethnicity – are you:

- Asian – Arab
- Asian – Bangladeshi
- Asian – Chinese
- Asian – Indian
- Asian – Pakistani
- Black – Black African
- Black – Black Caribbean
- White – White British
- White – White Irish
- Mixed – Asian and White
- Mixed – Black African and White
- Mixed – Black Caribbean and White
- Traveller – Gypsy
- Traveller – Irish Traveller
- Traveller – Romany
- prefer not to say
- other: \_\_\_\_\_

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## Self-assessment for equipment and minor adaptations

### Disability – if you are disabled, is your impairment:

- hearing
- hidden impairment
- learning disability
- long term medical condition
- mental health
- mobility – a wheelchair user
- mobility – not a wheelchair user
- speech
- visual
- none
- prefer not to say
- other: \_\_\_\_\_

### Sexual orientation – are you:

- bisexual
- gay man or lesbian
- heterosexual (straight)
- prefer not to say
- other: \_\_\_\_\_

### Religion or faith – is your religion or faith:

- Baha'i
- Buddhism
- Christianity
- Hinduism
- Islam
- Judaism
- Sikhism
- Taoism
- no religion
- prefer not to say
- other: \_\_\_\_\_

### Preferred language – is your preference:

- written
- spoken



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## Self-assessment for equipment and minor adaptations

Thank you for taking the time to complete your self-assessment.

Please post or email your self-assessment form to either:

- Thurrock First, Thurrock Council, Freepost ANG 1611, Grays, RM17 6SL
- [thurrock.first@thurrock.gov.uk](mailto:thurrock.first@thurrock.gov.uk)

### How we will use your information

We will use your information to provide the service requested. We may share your personal data between our services and with partner organisations, such as government bodies and the police. We will do so when it is of benefit to you, or required by law, or to prevent or detect fraud. To find out more, go to [thurrock.gov.uk/privacy](http://thurrock.gov.uk/privacy). Get free internet access at libraries and community hubs.

### Decision – office use only

Agreed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reasoning	
Duty Occupational Therapist name	
Signature	
Date	