Contact 1 *(Community-based)*

Not including telephone calls to make appointments

Date: Day Month Year | Carer involved? Y N n/a | Type of contact: ☐ Face-to-face ☐ Telephone

Your name

Profession *e.g. nurse* | **NHS Band**

Location: ☐ Home ☐ Clinic ☐ Other, specify:

☐ Client checklist provided in advance of the assessment

Carer information

Does the patient have a carer?

Defined as: main informal carer who provides the patient with practical support a minimum of once per week

☐ **Yes**

☐ **No**

Was a carer assessment completed?

☐ **Yes**

☐ **No** → Reason assessment not completed:

- ☐ Carer assessments routinely provided by other services
- ☐ Carer not present
- ☐ Carer declined
- ☐ Not offered *(reason)*:
- ☐ Other *(reason)*:

☐ **Patient does not have a carer (as per definition) but has care package provided** ☐ *Number of times a day/week*

Patient assessment questions

Remember to ask all of the questions *If there is a problem but it is not going to be addressed now, please tick the problem box and record in the action plan that it will be revisited next time.*	**Response**		**If NOT asked:** *indicate why*	
	No problem. No further action.	Problem. Please go to ACTION PLAN	Already addressed	Other. Please explain in notes section.
Transfer of Care: Reference guide 1				
Has a discharge plan been prepared by the hospital? Have you had a home visit? What was the outcome? *Discuss issues around knowledge and understanding of their care plan, their involvement, falls management and sources of information.*	☐	☐	☐	☐
Communication & Information: Reference guide 2				
Have you been given clear information about your condition, treatment and services available?	☐	☐	☐	☐

Patient's Name | Patient's D.O.B Day Month Year | NHS number:

Remember to ask all of the questions *If there is a problem but it is not going to be addressed now, please tick the problem box and record in the action plan that it will be revisited next time.*	**Response**		**If NOT asked:** *indicate why*	
	No problem. No further action.	Problem. Please go to ACTION PLAN	Already addressed	Other. Please explain in notes section.
Medicines & General Health: Reference guide 3				
Do you have any problems with your medication? *For example, side-effects, drug cocktail, non-prescription drugs.* Is medication being regularly reviewed by a doctor/nurse? *Medication can be recorded on page 4.*	☐	☐	☐	☐
Do you have any problems taking your medication? *For example, opening packets, remembering, swallowing (check for swallowing assessment).*	☐	☐	☐	☐
Do you have any other health problems? *Ask about smoking cessation, alcohol consumption, diet and weight loss.* Check if other health problems are being regularly reviewed.	☐	☐	☐	☐
Pain: Reference guide 4 *(assessment scale available)*				
Do you have any pain? Is the pain being treated? Is the treatment helping?	☐	☐	☐	☐
Mobility / Falls: Reference guide 5 *(assessment scale available)*				
Can you get around indoors?	☐	☐	☐	☐
Can you get out of your house?	☐	☐	☐	☐
How confident are you about carrying out various daily activities without falling?	☐	☐	☐	☐
How do you feel about your recovery so far? *Discuss patterns of physical and emotional recovery*	☐	☐	☐	☐

Patient's Name | Patient's D.O.B Day Month Year | NHS number:

Contact 1 patient assessment questions *(continued)*

Remember to ask all of the questions *If there is a problem but it is not going to be addressed now, please tick the problem box and record in the action plan that it will be revisited next time.*	Response		If NOT asked: *indicate why*	
	No problem. No further action.	Problem. Please go to ACTION PLAN	Already addressed	Other. Please explain in notes section.
Personal Hygiene & Dressing: Reference guide 6				
Are you having any difficulty with personal care like washing, cutting your nails, oral hygiene or dressing? Do you ever need help? *If applicable, discuss satisfaction with homecare services (e.g. dressing, bathing).*	☐	☐	☐	☐
Shopping & Meal Preparation: Reference guide 7				
Can you prepare your own meals?	☐	☐	☐	☐
Can you go shopping?	☐	☐	☐	☐
Are you getting the right food?	☐	☐	☐	☐
House & Home: Reference guide 8 *(assessment scale available)*				
Can you do your housework? Does anyone help you with your housework?	☐	☐	☐	☐
Do you have any problems with your accommodation? *If applicable, discuss satisfaction with homecare services (e.g. cleaning, shopping and laundry).*	☐	☐	☐	☐
Cognition: Reference guide 9 *(assessment scale available)*				
Do you often have a problem remembering things that happened recently? Do you often forget where you have put things? Do you find it difficult to concentrate?	☐	☐	☐	☐

Remember to ask all of the questions *If there is a problem but it is not going to be addressed now, please tick the problem box and record in the action plan that it will be revisited next time.*	Response		If NOT asked: *indicate why*	
	No problem. No further action.	Problem. Please go to ACTION PLAN	Already addressed	Other. Please explain in notes section.
Driving & General Transport: Reference guide 10 *(assessment scale available)*				
Do you have trouble with transport?	☐	☐	☐	☐
Finances & Benefits: Reference guide 11				
Do you have any difficulty managing your money?	☐	☐	☐	☐
Are you able to pay your bills?	☐	☐	☐	☐
Are you receiving all the benefits you are entitled to? *Use a benefits checklist.*	☐	☐	☐	☐
Continence: Reference guide 12 *(assessment scale available)*				
Do you ever have accidents with your bladder/bowel? How is this being managed?	☐	☐	☐	☐
Sexual Functioning: Reference guide 13 *(assessment scale available)*				
Some people after a stroke experience sexual problems such as lack of interest or practical difficulties. Have you experienced any changes sexually since your stroke?	☐	☐	☐	☐

Contact 1 patient assessment questions *(continued)*

Remember to ask all of the questions *If there is a problem but it is not going to be addressed now, please tick the problem box and record in the action plan that it will be revisited next time.*	**Response**		**If NOT asked:** *indicate why*	
	No problem. No further action.	Problem. Please go to ACTION PLAN	Already addressed	Other. Please explain in notes section.
Patient Mood: Reference guide 14 *(assessment scale available)*				
Have you recently felt very sad or fed up?	☐	☐	☐	☐
Have you felt anxious, frightened or worried? *Do you find it difficult to control your emotions?* *Discuss as appropriate frustration and irritability.* Have you been offered or are you having any treatment?	☐	☐	☐	☐
Do you have a partner, relative or friend you feel close to? Do you get on well? Can you talk about your worries or problems with them? *Discuss feelings of burden.*	☐	☐	☐	☐
Patient Social Needs: Reference guide 15				
How do you spend your day? Do you have enough to do? Are you happy with your social life? Do you wish you had more social contact with others? *Discuss work as appropriate, changes in role, relationships, personality, attitude and confidence. Enquire about self image and lack of energy.* *Discuss patient's perception of life since the stroke as compared with pre-stroke, and any thoughts about the future.*	☐	☐	☐	☐
Other				
Are you having any other problems relating to your stroke? *For example, swallowing, speech & language difficulties, sleeping, vision, numbness, oral health? Enquire if the patient has set self goals and what they are.* *Ask about their expectations and general patterns of physical and emotional recovery.* Discuss motivation and how much control they feel they have in their recovery.	☐	☐	☐	☐

Patient's Name | Patient's D.O.B Day Month Year | NHS number:

Notes

Patient's Name | Patient's D.O.B Day Month Year | NHS number:

Contact 1 goal and action planner

Contact 1

Client information: During your assessment you will plan and agree some goals to work towards or actions to take with your stroke care co-ordinator (SCC). The actions and goals may be set for you or for your SCC. After you have attempted your goals and actions, record the outcome below.

Duration of assessment contact (time spent with patient) Hours : Minutes (hours/mins)

Time spent discussing patient in MDT – *please complete table on back page.*

Time for additional note writing Hours : Minutes (hours/mins)

Problem ***(Please number problems)***	***Assessment question(s)/ Related reference guide(s) number***	***Goal or action***	***Patient / SCC***	***Date set***	***Date review***	***Review of outcome*** ***Please write*** ***a: Goal achieved,*** ***b: Nearly there but extra guidance required,*** ***c: Struggling with goal – To be reviewed in next contact***	***Duration spent on each SCC action between date set and date review.* (HH:MM)** *(exclude assessment contact time, include phone calls etc.)*
1. Difficulty going shopping because of parking and walking problems	5, 7 & 10	Obtain Blue badge	Patient	01.02.2009	01.03.2009	a. Blue Badge obtained	20 mins
LoTS care trial team use only: Total number of problems identified	Reference guides used: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 Other	Total number of goals / actions:	Total number of patient goals / actions:			Total number achieved:	Total duration: Hours : Minutes

Patient's Name Patient's D.O.B Day Month Year NHS number:

Patient's Name Patient's D.O.B Day Month Year NHS number:

Contact 1 CARER assessment questions *(optional)*

Date: Day Month Year

Type of contact: ☐ Face-to-face ☐ Telephone

Remember to ask all of the questions *If there is a problem but it is not going to be addressed now, please tick the problem box and record in the action plan that it will be revisited next time.*	**Response**		**If NOT asked:** *indicate why*	
	No problem. No further action.	Problem. Please go to ACTION PLAN	Already addressed	Other. Please explain in notes section.
Transfer of Care: Reference guide 1				
Check issues around involvement in care plan and understanding of situation	☐	☐	☐	☐
Communication & Information: Reference guide 2				
Have you been given clear information about [*the patient's*] condition?	☐	☐	☐	☐
Medicines & General Health: Reference guide 3				
Do you have any health concerns? Are you receiving treatment? Is the treatment helping?	☐	☐	☐	☐
Mobility / Falls: Reference guide 5				
Have you been shown how to handle [*the patient*]?	☐	☐	☐	☐
Do you have any concerns about moving and handling [*the patient*]?	☐	☐	☐	☐
Do you know what to do in the event of [*the patient*] falling?	☐	☐	☐	☐

Patient's Name | Patient's D.O.B Day Month Year | NHS number:

Remember to ask all of the questions *If there is a problem but it is not going to be addressed now, please tick the problem box and record in the action plan that it will be revisited next time.*	**Response**		**If NOT asked:** *indicate why*	
	No problem. No further action.	Problem. Please go to ACTION PLAN	Already addressed	Other. Please explain in notes section.
Personal Hygiene & Dressing: Reference guide 6				
Do you have any problems providing personal care for [*the patient*] like washing, cutting their nails, dressing or toileting? Do you ever need help?	☐	☐	☐	☐
Shopping & Meal Preparation: Reference guide 7				
Do you have trouble getting to the shops? Do you have any problems preparing meals?	☐	☐	☐	☐
House & Home: Reference guide 8 *(assessment scale available)*				
Do you have any trouble with household chores (e.g. cleaning, laundry)? Do you need help maintaining the garden or with general household jobs (e.g. changing fuses, checking smoke alarm battery etc.)? *If applicable, discuss satisfaction with homecare services (e.g. cleaning, shopping, laundry).*	☐	☐	☐	☐

Patient's Name | Patient's D.O.B Day Month Year | NHS number:

Contact 1 CARER assessment questions *(optional)*

Remember to ask all of the questions *If there is a problem but it is not going to be addressed now, please tick the problem box and record in the action plan that it will be revisited next time.*	Response		If NOT asked: *indicate why*	
	No problem. No further action.	Problem. Please go to ACTION PLAN	Already addressed	Other. Please explain in notes section.
Driving & General Transport: Reference guide 10 *(assessment scale available)*				
Do you have any trouble with transport?	☐	☐	☐	☐
If the patient is eligible: Has a blue badge been applied for?	☐	☐	☐	☐
Do you require refresher lessons for driving?	☐	☐	☐	☐
Finances & Benefits: Reference guide 11				
Do you have any difficulty managing your money? Are you able to pay your bills? Are you sure you are receiving all the benefits you are entitled to? *Check against benefits checklist.*	☐	☐	☐	☐
Sexual Functioning: Reference guide 13 *(assessment scale available)*				
Some couples experience sexual problems after stroke. These may include practical problems or psychological difficulties such as fear or lack of interest. Have you or your partner experienced any changes sexually since the stroke?	☐	☐	☐	☐

Patient's Name _____ Patient's D.O.B Day Month Year _____ NHS number: _____

Remember to ask all of the questions *If there is a problem but it is not going to be addressed now, please tick the problem box and record in the action plan that it will be revisited next time.*	Response		If NOT asked: *indicate why*	
	No problem. No further action.	Problem. Please go to ACTION PLAN	Already addressed	Other. Please explain in notes section.
Patient Mood: Reference guide 14 *(assessment scale available)*				
Do you find it difficult or stressful caring for [*the patient*]?	☐	☐	☐	☐
Carer Social and Emotional Needs: Reference guide 16:				
Do you feel you need a break, or much more support for yourself? *Discuss barriers to taking a break and what is available to them (e.g. local support groups, respite homes, other relatives).*	☐	☐	☐	☐
Other				
Do they have any other concerns or problems which have not been covered? *If not already covered, discuss carers' support groups and the benefits of a carer's assessment with social services.*	☐	☐	☐	☐

Patient's Name _____ Patient's D.O.B Day Month Year _____ NHS number: _____

Contact 1 CARER goal and action planner *(optional)*

Contact 1 (carer)

Client information: During your assessment you will plan and agree some goals to work towards or actions to take with your stroke care co-ordinator (SCC). The actions and goals may be set for you or for your SCC. After you have attempted your goals and actions, record the outcome below.

Duration of assessment contact (time spent with carer) Hours : Minutes (hours/mins)

Time for additional note writing Hours : Minutes (hours/mins)

Problem ***(Please number problems)***	***Assessment question(s)/ Related reference guide(s) number***	***Goal or action***	***Carer/ SCC***	***Date set***	***Date review***	***Review of outcome*** ***Please write*** ***a: Goal achieved,*** ***b: Nearly there but extra guidance required,*** ***c: Struggling with goal – To be reviewed in next contact***	***Duration spent on each SCC action between date set and date review.* (HH:MM)** *(exclude assessment contact time, include phone calls etc.)*
LoTS care trial team use only: Total number of problems identified	Reference guides used: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Other	Total number of goals / actions:	Total number of carer goals / actions:			Total number achieved:	Total duration: Hours : Minutes

Patient's Name Patient's D.O.B Day Month Year NHS number:

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