nova scotia health authority

**Nova Scotia Health Authority's Dual Diagnosis Program**
**Community Outreach, Assessment, Support and Treatment Team (COAST)**

# ASSESSMENT FORM FOR CAREGIVERS

## Form is to only to be completed by family or support

For the most complete evaluation, please provide these additional items:

1. The most recent educational and psychological evaluations, including a copy of the Individual Program Plan (if appropriate)

2. All programs (previous and current) designed to treat the individual's target behaviours

To start the referral process **this** form and the **Physician Referral Form** must be completed.

If you have any questions or need assistance, please contact us at 902-464-6025.

**Please complete in black ink only and return this form to:**

**Intake – COAST Team, 300 Pleasant St., Dartmouth, NS B2Y 3Z9 Fax: 902-464-3044**

Completed by: _____ Date completed: _____

Contact phone number: _____ Relationship to person referred: _____

### PART I. BIOGRAPHICAL INFORMATION

1. Name: _____ Date of Birth: _____ Health card #: _____
2. Current Address: _____

_____

Contact Person: _____ Telephone:_____

3. Next of Kin Name(s): _____ Telephone:_____ Cell:_____

   Address: _____ Relationship: _____

4. a. Who provides consent for health care decisions for the individual? _____

   b. Contact information for person consenting for health care decisions: _____

_____

5. Has the individual been seen before by the COAST team or Emerald Hall YES NO If yes, last date seen: _____
6. Is the individual involved with another mental health service? YES NO If yes, who:_____

### PART II. PSYCHOSOCIAL BACKGROUND

1. Current residence: □ With parents □ Independently □ Residential Facility □ Small Option/Group Home

   Name of Agency:_____

nova scotia health authority

**Nova Scotia Health Authority's Dual Diagnosis Program**
**Community Outreach, Assessment, Support and Treatment Team (COAST)**

# ASSESSMENT FORM FOR CAREGIVERS

Name: _____

Level of support/supervision (e.g., constant, 1:1, minimal, etc.): _____

2. Are there other individuals who provide significant support to the person? YES NO

   If yes, identify the relationship (e.g., friend, aunt, grandparent, neighbour, etc. ):_____

3. Does the individual receive support from the Department of Community Service? YES NO

   If yes, what type of support is received (e.g., SPD program, respite support, income assistance, etc.,)?

   _____

   Care Coordinator: _____

## PART III. PRESENT ABILITY

1. Please score the items listed below using a number that most closely describes the person's ability over the past 6 months.

   ***1 = Independent*** – no assistance required

   ***2 = Assistance*** – some assistance required

   ***3 = Dependent*** – total assistance required

| | | Independent | Assistance | Dependent |
|---|---|---|---|---|
| a. | Toileting | □ | □ | □ |
| b. | Walking | □ | □ | □ |
| c. | Self-Care (e.g. bathing, dressing, etc.) | □ | □ | □ |
| d. | Eating | □ | □ | □ |

2. **Sleep:** Has there been a recent change in sleep pattern? YES NO

   Please explain: _____

   _____

   _____

Time to bed: _____ pm Time to wake: _____ am

3. **Communication:**

   Method of communication: □ Words □ Gestures □ Pictures □ Sign Language □ iPad/Computer Device

   Does the person read and/or write? YES NO

4. Has there been a significant change in the person's sleep, communication abilities, and personal care skills over the past 6 months? YES NO Briefly describe:_____

nova scotia health authority

**Nova Scotia Health Authority's Dual Diagnosis Program**
**Community Outreach, Assessment, Support and Treatment Team (COAST)**

# ASSESSMENT FORM FOR CAREGIVERS

Name:_____

## PART IV. NUTRITION

1. Present Weight: _____ kgs  Has there been a significant weight change over the past 6 months?  YES  NO

2. Present Height: _____

3. Diet:  □ Regular  □ Chopped  □ Pureed  □ Low fat  Other: _____

4. Describe any feeding problems (chewing, swallowing, choking, eating too fast, vomiting, food aversions, allergies): _____

_____

## PART V. PROBLEM BEHAVIOURS

1. What is the presenting problem/concern? Please provide as much detail as possible, including the intensity (mild, moderate, severe), duration (1hr/day, 20min, etc.), frequency (once a day, etc.), and timeline (how long has this been happening?)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. In what settings do these behaviours occur?  □ Home  □ School/Work  □ Community  □ Other

   Describe: _____

_____
_____
_____
_____

nova scotia health authority

**Nova Scotia Health Authority's Dual Diagnosis Program**
**Community Outreach, Assessment, Support and Treatment Team (COAST)**

# ASSESSMENT FORM FOR CAREGIVERS

Name:_____

3. How long has the individual been engaging in the problem behaviour(s)?

□ Within the past 6 months □ More than 6 months but less than 1 year □ More than 1 year

4. When is the problem behaviour(s) likely to occur?

□ During mealtimes □ Dressing □ Bathing

□ When individual is left alone or unattended □ When the individual cannot have something s/he wants

□ When lots of people are around □ Time of day: _____

□ When demands are placed on the individual □ Other:_____

5. Are there any occasions when the problem behaviour(s) rarely or never occur? _____

_____

6. How do people (staff, parents, etc.) typically respond when the individual engages in the problem behaviour(s)?

_____

a. Is a formal program currently being used? NO YES **Please include a copy of this program if one exists.**

b. How long has the program been in place? _____

7. Was the onset of the problem behaviour(s) associated with any specific event or series of events?

_____

_____

8. What treatments have been tried to address the problems behaviours listed above (e.g., positive reinforcement, punishment, protective equipment, physical restraint, medication, counseling, etc.)

_____

_____

_____

_____

9. Please provide any additional information that you find relevant: _____

_____

_____

*** * Thank you very much for your assistance. See Page 1 for instructions on returning the completed form. * ***