**Home Assessment (Occupational Therapy) Report**

**1. Background Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of assessment** | dd/mm/yy | **Claim number** |  |
| **Name of employee** |  | | |
| **Compensable condition** |  | | |

**2. ASSESSMENT TYPE**

|  |  |
| --- | --- |
|  | Initial assessment: Tasks for which the employee has requested assistance and tasks that adversely impact the employee’s current rehabilitation (return to work) program. |
|  | Review assessment: Limited to tasks for which the employee currently receives assistance and additional tasks that have been requested since an initial assessment. |

**3. Household assistance, attendant care and childcare services currently funded by Comcare**

|  |  |  |
| --- | --- | --- |
| **Service** | **Hours/frequency** | **Specific tasks** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**4. Other household, personal care or child care tasks for which the employee has requested assistance**

|  |  |
| --- | --- |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |
| **5.** |  |

**5. Household, attendant care or child care services the employee used prior to their compensable injury**

|  |  |  |
| --- | --- | --- |
| **Service** | **Hours/frequency** | **Specific tasks** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**6. Members of the employee’s family and people living with the employee**

**Note:** Family and household members should perform tasks they could reasonably be expected to perform.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship to employee** | **Distance of home from the employee’s home** | **Hours spent in employment or other activities and capacity to assist the employee** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**7. Details of the home environment**

|  |  |
| --- | --- |
| **Type of home (e.g. house, flat)** |  |
| **Number of bedrooms** |  |
| **Number of bathrooms** |  |
| **Number of living areas** |  |
| **Type of flooring (e.g. carpet or tiles)** |  |
| **General presentation** |  |
| **Outdoor areas** |  |
| **Does the employee have any assistive equipment?** |  |

**8. Employee’s presentation**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Details and comments** | **Reported** | **Observed** |
| Height | [Comment if impacts ability to perform tasks] |  |  |
| Weight | [Comment if impacts ability to perform tasks] |  |  |
| Range of movement/ hand dominance | [Comment if impacts ability to perform tasks] |  |  |
| Sitting tolerance | [Minimum / maximum limits] |  |  |
| Standing tolerance | [Minimum / maximum limits] |  |  |
| Walking tolerance | [Minimum / maximum limits] |  |  |
| Lifting capacity | [Enter details] |  |  |
| Endurance | [e.g. limits for relevant activities] |  |  |
| Ability to perform other tasks beyond the scope of this assessment | [e.g. other personal or domestic tasks, driving, social or sporting activities etc.] |  |  |
| Psychological issues relevant to this assessment | [Enter details] |  |  |

**9. Analysis of tasks**

Could a person living with the employee or member of the employee’s family [listed at 6. Above] be reasonably expected to perform the tasks or some of the tasks for the employee (i.e. without substantial disruption to their employment or other activities)? If yes, who? If, no please explain why?

|  |
| --- |
|  |

Did the employee perform the tasks before their injury? If yes, how often?

|  |
| --- |
|  |

Could the employee perform the tasks before their injury?

|  |
| --- |
|  |

Does the employee require assistance to perform the tasks now due to their compensable injury? If yes, explain the functional limitations preventing the employee from performing each task and how they are related to the employee’s compensable injury.

|  |
| --- |
|  |

Are there any factors other than the employee’s compensable injury impacting their ability to perform the tasks (e.g. non-compensable conditions)?

|  |
| --- |
|  |

Are the tasks impacting the employee’s current rehabilitation (return to work) program? (if they have one)

No  Yes  If yes, explain how?

|  |
| --- |
|  |

Could you train the employee in adaptive techniques or the use of equipment to enable them perform the tasks independently?

No  If no, explain why?

Yes  If yes, please train the employee during the assessment if possible and describe the level of independence achieved?

If another occupational therapy session or the provision of equipment could empower the employee to perform a task independently, please provide details of the session or equipment and a quote for the cost.

|  |
| --- |
|  |

**10. Recommendations**

Based on your analysis above and Comcare’s intervention preferences below, what do you recommend for each task, to maximise the employee’s independence while meeting their reasonable needs?

**Intervention preference hierarchy**

1. Identify how the employee can perform the task independently

2. Identify member(s) of the employee‘s family or household who could reasonably be expected to perform the task (i.e. without substantial disruption to their employment or other activities)

3. Train the employee in adaptive techniques and/or the use assistive equipment enabling them to perform the task, or

4. Identify an amount and frequency of professional household and attendant care services reasonably required for tasks and a gradual reduction of services (where reasonable) to achieve maximum independence.

Explain the reasoning behind your recommendations based on the available evidence. If professional services are reasonably required, explain why and complete the table below.

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| **Task** | **Hours of professional service required to perform task** | **Dates service will be reasonably required** | |
| **From** | **To** |
| Complete this table only if professional services are required | [hours] | dd/mm/yyyy | dd/mm/yyyy |
|  |  | dd/mm/yyyy | dd/mm/yyyy |
|  |  | dd/mm/yyyy | dd/mm/yyyy |
|  |  | dd/mm/yyyy | dd/mm/yyyy |
|  |  | dd/mm/yyyy | dd/mm/yyyy |
| **Expected date employee will be able to undertake tasks independently** dd/mm/yyyy | | | |

**11. Contact with Treating Medical Practitioner**

Did you contact the employee’s treating medical practitioner? Yes  No

|  |  |  |
| --- | --- | --- |
| **Name of practitioner** | **Date of contact** | **Summary of conversation with medical practitioner** |
|  | dd/mm/yyyy | What was the medical practitioner’s advice regarding the employee’s abilities and limitations related to the compensable condition?  Does the medical practitioner support your recommendations? If not, why? |

**12. Comments of the employee regarding this assessment**

|  |
| --- |
|  |

**13. Comments of occupational therapist regarding this assessment**

|  |
| --- |
|  |

[Enter name]

Occupational Therapist

B. App. Sc. (O.T.)

CC: