ANNEX A

ASSESSMENT TOOL		
NAME:	NRIC	
	DATE	

SECTION A : FUNCTIONAL STATUS

a)	**Mobility**	❑ Walking (Independent) ❑ Walking (With Assistance) : ❑ Wheelchair Bound : ❑ Bed Bound	❍ Walking Stick ❍ Quad Stick ❍ Walking Frame ❍ Independent ❍ With assistance		
b)	**Toileting:**	❑ Independent	❑ Needs assistance	❑ Dependent:	❍ Catheters ❍ Diapers
c)	**Showering:**	❑ Independent	❑ Needs assistance	❑ Dependent/ Unable	
d)	**Balance:**	❑ Difficult to stand up	❑ Difficult to turn self around	❑ Dizziness	❑ Unsteady gait
e)	**Transfer:**	❑ Independent	❑ Needs assistance	❑ Dependent/ Unable	
f)	**Mental Status:**	❑ Rational	❑ Confused	❑ Unable to Respond	
g)	**Dyspnea: (Shortness of breath)**	❑ No symptom	❑ Present doing strenuous activities (e.g. House chores / shopping)	❑ Present doing daily activities	❑ Present at rest
h)	**Falls:**	❑ No fall in 3 months	❑ One fall in 3 months	❑ Two or more falls in 3 months	
i)	**Vision:**	❑ Normal (Able to see print in newspaper)	❑ Moderate difficulty (Unable to see newspaper but able to identify objects)	❑ Severe difficulty (Object identification in question but eyes appear to follow objects)	❑ No vision
j)	**Hearing**	❑ Normal— (No difficulty in normal conversation)	❑ Moderate difficulty— (Problem hearing normal conversation)	❑ Severe difficulty— (Difficulty in all situations)	❑ No hearing
k)	**Meal preparation** — Able to prepare meals (e.g. planning meals, assembling ingredients, cooking, setting out food and utensils):		❑ Yes	❑ No (Explain) ______________________ ______________________	
l)	**Home maintenance** — Able to perform normal house chores (e.g. cleaning dishes, mopping, sweeping making bed, tidying up, laundry, wash toilet):		❑ Yes	❑ No (Explain) ______________________ ______________________	
m)	**Personal hygiene / grooming** — Able to manage personal hygiene (e.g. including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands)		❑ Yes	❑ No (Explain) ______________________ ______________________	

ASSESSMENT TOOL

NAME:	NRIC
	DATE

SECTION B: ENVIRONMENT

a)	Lift landing:	❑ Yes	❑ No
b)	Lift landing – kerb:	❑ Yes	❑ No
c)	Food Amenities: Accessible within walking distance and manageable by applicant	❑ Yes	❑ No
d)	Access to common corridor: Steps from house to corridor	❑ Yes	❑ No
e)	Access to kitchen – kerb / step:	❑ Yes	❑ No
f)	Access to toilet – kerb / step:	❑ Yes	❑ No
g)	Home modified done (Installed grab bars, sitting toilet, ramps etc)	❑ Yes	❑ No
h)	Transport: Able to navigate	❑ Yes	❑ No
i)	Access to public transport:	❑ Walking distance to bus stop / MRT	❑ Transfer of bus / MRT required

SECTION C: MEDICAL INFORMATION

History of

a)	Fracture / amputation	❑ Yes (Specify: ____________________)	❑ No
b)	Hemiplegia (paralysis of one side of the body)	❑ Yes	❑ No
c)	Paraplegia (paralysis of both lower limbs due to spinal disease or injury)	❑ Yes	❑ No
d)	Quardriplegia (the loss of use of all of his/her limbs)	❑ Yes	❑ No
e)	Parkinson's disease	❑ Yes	❑ No
f)	Dementia	❑ Yes	❑ No
g)	Chronic Obstructive Pulmonary Disease	❑ Yes	❑ No
h)	Cerebral Palsy	❑ Yes	❑ No
i)	Psychiatric Condition	❑ Yes (Specify: ____________________)	❑ No
j)	Lower limb Weakness	❑ Yes	❑ No
k)	Osteoarthritis or Rheumatoid Arthritis	❑ Yes	❑ No
l)	Stroke	❑ **Yes**	❑ No
m)	Heart Disease	❑ **Yes**	❑ No
n)	Renal Disease	❑ **Yes**	❑ No
o)	Diabetes Mellitus	❑ **Yes**	❑ No
p)	Infectious Diseases	❑ **Yes (Specify: ____________________)**	❑ No
q)	Others: (Specify:____________________)		

SECTION D: ASSESSOR'S INFORMATION & FEEDBACK

Name: ____________________

Designation/ Dept/ Institution: ____________________/ ____________________/ ____________________

Telephone/ Fax: ____________________/ ____________________

Email address: ____________________

Date (dd/mm/yyyy): ____________________

Remarks:

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