

Types of Care and Assistance Needed

Preparation for COPES Referral – Client Needs and Wants



Activities of Daily Living

| ACTIVITY | ACCOMPLISHES ALONE | NEEDS <u>SOME</u> HELP | NEEDS <u>MUCH</u> HELP |
|--------------------------|--------------------|------------------------|------------------------|
| Bathing | | | |
| Dressing | | | |
| Grooming | | | |
| Toileting | | | |
| Eating a nutritious diet | | | |
| Getting out of bed | | | |
| Getting out of chair | | | |
| Walking | | | |

Notes: _____

Does client agree with this assessment? YES NO UNKNOWN

Instrumental Activities of Daily Living

| ACTIVITY | ACCOMPLISHES ALONE | NEEDS <u>SOME</u> HELP | NEEDS <u>MUCH</u> HELP |
|-----------------------------|--------------------|------------------------|------------------------|
| Using the telephone | | | |
| Shopping for personal items | | | |
| Transportation | | | |
| Managing money | | | |
| Doing laundry | | | |
| Doing light housework | | | |
| Preparing meals | | | |
| Walking | | | |

Notes: _____

Does client agree with this assessment? YES NO UNKNOWN

Client Name: _____

Date of Mini-Assessment: _____

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Functional Status

How do the following affect the person's ability to function?

| LIMITATION | NO EFFECT | SOME EFFECT | MAJOR EFFECT |
|--------------------------|-----------|-------------|--------------|
| Hearing | | | |
| Vision | | | |
| Perception | | | |
| Orientation | | | |
| Thinking | | | |
| Memory | | | |
| Decision-making/judgment | | | |
| Physical dexterity | | | |
| Balance | | | |
| Strength | | | |
| Energy | | | |
| Bladder/bowl control | | | |
| Arthritis | | | |
| Hypertension | | | |
| Heart disease | | | |
| Diabetes | | | |
| Physical deformity | | | |
| Depression | | | |

Notes: _____

Does client agree with this assessment? YES NO UNKNOWN

Does client have an informal support network? If so, list names/relation and what types of care they assist client with?

Does client have any social service supports? If so, list names/role and what types of care they assist client with?

What services does client say that they want and need?

Client Name: _____

Date of Mini-Assessment: _____