Central Manchester University Hospitals NHS
NHS Foundation Trust

DEPARTMENT OF THERAPEUTIC & SPECIALISED PLAY SERVICES

Outcomes of Person Centred Assessment of Child's Individual Specific Needs

(To be placed on the front of Childs notes/care plan)

Patients Name …… **Hospital No**……. **Clinician**……..

Assessment of Disability Completed:	Yes/No	Enclosed:	Yes/No
Translator /Interpreter required	Yes/No	Arranged	Yes/No

Date to be Admitted/Seen ……

Ward/Area ……

Actions Required…….

……

Important points to be aware of on Admission or Appointment :

Red **High Priority /Dislikes**

-
-
-
-

Amber **Medium priority**

-
-
-
-

Green **Likes/Interests**

-
-
-

Assessment Completed Via:

Telephone ☐ Ward/Department ☐ Other ☐

Parent ☐ School/Nursery/Senco ☐ Learning Disability Nurse ☐

Signed …… **Name** ……..

Professional Status …… **Date Completed** ……..

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DEPARTMENT OF THERAPEUTIC & SPECIALISED PLAY

PERSON CENTRED ASSESSMENT FOR A CHILD/YOUNG PERSON WITH A DISABILITY e g AUTISM

TO BE COMPLETED PRIOR TO ADMISSION/CLINIC

Name…… DOB……...

Disability…….. Referred by ……..

Hospital No …… Name of Clinician……

Ward/Area……. Date……

Ethnicity…….. Contact No……..

Common Assessment Framework been completed Yes ☐ No ☐

Mental Capacity Assessment [ask if over 16] N/A ☐ Yes ☐ No ☐

History

1. Has your child been in hospital before?

Yes ☐ No ☐

If yes, please state the experience

……

……

Communication

2. What method of communication does your child/young person use?

Use Pictures	☐	Sign Language	☐
Verbal	☐	Auditory/ Hearing	☐
Use single words	☐	Other	☐
Sensory	☐	Interpreter /Translator required	YES/NO

Does you or your child have a communication passport	Yes	☐	No	☐
Would like photographs (social story) forwarded	Yes	☐	No	☐
Patient plan/journey to be devised	Yes	☐	No	☐

Preparation to Hospital

3 . Would your child/young person benefit from a pre-hospital visit to see the area?

Yes ☐ No ☐

Comments……

……

NAME …… HOSPITAL NO ……CLINICIAN…….

3. Is your child/young person able to give eye contact when communicating verbally?

   Yes ☐ No ☐ Sometimes ☐

4. Are there any familiar sayings that you or your child/young person uses regularly which would be useful for the staff to know?

   Yes ☐ No ☐ Sometimes ☐

   If yes, please state……..

   ……

5. Does your child/young person allow contact/touching?

   Yes ☐ No ☐ Sometimes ☐

Child/Young Persons Interests

6. Please tell us about your child/young person's personal likes/obsessions

   ……

   ……

7. What does your child/young person like playing with?

   Books ☐ Drawing/crayoning ☐ Play alone ☐

   Musical games ☐ Computer/ICT games ☐ Sensory play ☐

   Television/DVD ☐ Imaginative play ☐ Other ……

   Further Comments…Would you bring anything in particular with you to occupy your child ?

   Yes ☐ No ☐

……..

……

7b How much support do you feel the person accompanying your child would require when in a restricted environment **?**

……

Fears/Obsession

8. Please tell us about your child/young person's dislikes, fears (e.g. doesn't like the colour red any foods etc)

   ……
   ……

Behaviour

NAME …… HOSPITAL NO ……CLINICIAN……

9a. Is your child/young person violent or aggressive?

Yes ☐ No ☐ Sometimes ☐

Comments……

……

Any additional mental health disorders e g Anxiety ☐ or Depression ☐

9b. Will he/she be likely to attack staff or other child/young person?

Yes ☐ No ☐ Sometimes ☐

Comments……

9c. Does your Child/Young Person self harm?

Yes ☐ No ☐ Sometimes ☐

Further Comments……..

……

10a. What things/events may trigger your child/young person to behave angrily, aggressively or go into a tantrum?

Sudden noise ☐ Too much noise ☐ Absence of structure ☐

Long waits ☐ Change of routine ☐ Too many people ☐

Environment ☐ Other.....

Further Comments……..

10b. What calms your child/young person down if he/she becomes anxious?

……...

……

11. Does your child/young person use a behavioural system which is important to be carried out while in hospital (e.g. coloured spots/traffic light system and reward charts)?

Yes ☐ No ☐ Sometimes ☐

If yes, please state:

……

……

12. Will your child/young person tolerate being on an open ward?

NAME …… HOSPITAL NO ……CLINICIAN……

Yes ☐ No ☐ Sometimes ☐

If no please state reason and any further comments:

Clinical Treatments

13. Will your child/young person tolerate any of the following Medical Procedures/Experiences? E.g. Procedures on Wards/Clinics such as:-

Weight/Height	Yes	☐	No	☐	Sometimes	☐
Temperature	Yes	☐	No	☐	Sometimes	☐
Wearing a hospital name band	Yes	☐	No	☐	Sometimes	☐
If no photograph ID arranged	Yes	☐	No	☐	Sometimes	☐
Examined by doctor/nurse etc	Yes	☐	No	☐	Sometimes	☐
Taking medicine or tablets	Yes	☐	No	☐	Sometimes	☐
Blood pressure taken	Yes	☐	No	☐	Sometimes	☐
Attending clinics e.g. out patients	Yes	☐	No	☐	Sometimes	☐
Tolerate being in busy waiting areas	Yes	☐	No	☐	Sometimes	☐
Needle/injection procedures	Yes	☐	No	☐	Sometimes	☐
Blood tests	Yes	☐	No	☐	Sometimes	☐
Injections	Yes	☐	No	☐	Sometimes	☐
Cannulas	Yes	☐	No	☐	Sometimes	☐
Going to theatre	Yes	☐	No	☐	Sometimes	☐
Wearing a theatre gown	Yes	☐	No	☐	Sometimes	☐
Having a mask on	Yes	☐	No	☐	Sometimes	☐
Has your child had sedation before	Yes	☐	No	☐	Sometimes	☐
How did your child respond _____						
Going on the theatre trolley	Yes	☐	No	☐	Sometimes	☐
Having a cannula post theatre	Yes	☐	No	☐	Sometimes	☐
Having an x-ray?	Yes	☐	No	☐	Sometimes	☐
Having a scan?	Yes	☐	No	☐	Sometimes	☐
Having plasters placed on body	Yes	☐	No	☐	Sometimes	☐

NAME …… HOSPITAL NO ……CLINICIAN……

Any concerns re your child post surgery/theatre
Yes ☐ No ☐ Sometimes ☐

Comments……

Other e.g. dressings…….

Comments……
Do you or your child have any mobility problems ?

Yes ☐ No ☐

Comments ----------

Education

14. What Nursery/School/College does your child/young person attend?
……

Contact details …….....

Email address.....

15. Would it help to speak with you or the nursery, school, college to help with the time in hospital?

Yes ☐ No ☐

Additional information

16. Is your child/young person having any other treatments/tests or appointments within the hospital i.e. X-ray, EEG, dental?

Yes ☐ No ☐ Sometimes ☐

If yes, please state……..
……

17. Is there any further information we need to know to help you or your child/young person when in Hospital or having treatments?

Yes ☐ No ☐

If yes, please state…….

Risk Assessment required Yes ☐ No ☐

<u>Assessment Completed Via:</u>

Telephone ☐ Ward/Department ☐ Other ☐

Parent ☐ School/Nursery/Senco ☐ Learning Disability Nurse ☐

COMPLETED BY:

SIGNATURE …… DATE……

PRINT NAME …… DESIGNATION…….....