

Print Name: .....

Date of Birth: .....

MRN Number: .....

NHS Number: .....

**Occupational Therapy**  
Nuffield Orthopaedic Centre  
Windmill Road  
Headington  
Oxford OX3 7HE

# Occupational Therapy Self Screen Form

You have been given this form upon your arrival to the Pre-operative Assessment Clinic.

The information you provide will help when planning your timely and safe discharge from hospital.

*Please complete all the questions and hand it back to the reception desk as soon as possible.*

Please tick below as appropriate	
Do you live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If <b>no</b> please state who you live with	
Do you feel well supported by family/friends/neighbours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can family/friends/neighbours help with shopping during your recovery?	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a direct caring responsibility for another person on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes please provide details:</b>	

Care package	
Do you have a care package?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If <b>yes</b> who funds the care package?	<input type="checkbox"/> privately funded <input type="checkbox"/> adult social care <input type="checkbox"/> other
What do the carers provide support with and how often do they visit?	
<b>Generally do you have any concerns</b> about being discharged from hospital after your planned surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Specifically</b> , if you have answered yes are your concerns to do with any of the following?	
a) Managing your personal care	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Meal preparation	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Returning to care for someone else during your own recovery	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Transfers (e.g. bed, chair, toilet)	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Other. <b>Please detail</b>	

*Please turn over and ensure all questions are answered*



## Mobility

Do you currently use any of the following (*please tick any that are appropriate to you*)

none     sticks     crutches     walking frame     wheeled walker     wheelchair

Are you falling or having "near misses" regularly?  Yes  No

Have you had a fall in the last 6 months?  Yes  No

If you have answered 'yes' - approximately how many times have you fallen or had a "near miss" in the last 6 months?

Where did the fall(s) occur?

What treatment or help was required?

What was the cause of the fall(s) (i.e dizziness, trip over obstacle, leg giving way)?

## Destination on discharge

Do you plan to return to your own home on discharge?  Yes  No

If **no** please detail your plan

## Details of the property you are planning to be discharged to: (Please tick as appropriate)

house     bungalow     mobile home     ground floor flat     flat first floor or higher  
 other. **Please detail**

How many steps are there to access the property?

Will you need to complete a full flight of stairs on discharge?  N/A  Yes  No

Is there a banister or other railing along your staircase?

left hand side ascending     right hand side ascending     both sides     none

Is there a lift in the property?  Yes  No

If **yes** please state type of lift (i.e. stair lift or through floor lift)

Please detail any steps inside your property other than access and the main stairs

Where is the toilet located in the property you are returning to?

upstairs only     downstairs only     both upstairs and downstairs

What washing facility is in the property?

bath     shower over bath     shower cubicle     other. **Please detail**

Do you currently have any equipment or adaptations in your home to help you with daily living?  
(This may include raised toilet seat, commode, extra rails, stair lift etc..)

Yes  No

If yes please give details

*Please turn over and ensure all questions are answered* 

Signature: ..... Date: .....

**Thank you for completing this form.**