**PRE-OPERATIVE SELF ASSESSMENT AHP (ALLIED HEALTH PROFESSIONALS) FORM**

Please fill out the form below and return to: [Nhsh.ahpntc@nhs.scot](mailto:Nhsh.ahpntc@nhs.scot) or NTC-H, Inverness Campus, Inverness, IV2 5NA or OT Department, Raigmore Hospital, Old Perth Road, Inverness, IV2 3UJ

There is space at the end to add any additional comments you feel may be relevant.

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| **Name** |  | | |
| **CHI** |  | | |
| **Address** |  | | |
| **Phone Number** |  | | |
| **E-mail address** |  | | |
| **Proposed surgery and date (if known)** | Total Hip Replacement | Total Knee Replacement | Half-Knee Replacement |

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| **HOME SITUATION** | | | | | |
| **Type of accommodation** | House | Flat | Bungalow | Sheltered | Other |
| **Access to accommodation** | Level | Steps | Stairs | Ramp | Other |
| Grab rail/handrails | Yes | On the left | On the right | No rail | |
| **Internal Stairs** | Yes | | No | | |
| Handrail/Bannister | Yes | On the left | On the right | No banister | |
| **Bedroom** | Entry Level | | Upstairs | | Both |
| **Toilet** | Entry Level | | Upstairs | | Both |
| **Shower/Bath** | Entry Level | | Upstairs | | Both |
| Walk in Shower | | Over Bath | | Bath |
| **Do you live** | With someone | Dependents | | Alone | |
| If you live alone, will someone be staying with you after your operation? | | | | Yes | No |
| If no, what are your plans for managing at home? | | | |  | |

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| **MOBILITY** | | | | |
| **Are you able to walk** | | | | |
| Without an aid | With an aid  (only required for outdoors) | With an aid  (only required for indoors) | With an aid  (for indoors and outdoors) | Unable to walk/transfers only |
|  |  |  |  |  |
| **If you use a walking aid, please give details:** | | | | |
| **Do you require physical assistance when you walk?** | | | Yes | No |
| If yes, please give details: | |  | | |
| **How far are you able to walk?** | | | | |
| Unlimited | More than 1 mile | Less than 1 mile | Indoors only | Transfers only |
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| **STAIRS/STEPS** | | | | | |
| **Are you able to safely go up and down:** | | | | | |
|  | Yes  without rail | Yes  with a rail | Yes  with an aid | Yes  with physical assistance | Unable |
| **Single Step** |  |  |  |  |  |
| **Stairs** |  |  |  |  |  |

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| **TRANSFERS**  **How are you managing to get on and off these items** | | | | | |
|  | Independent | Independent  (using arms/pushing up on something) | With physical assistance (please give details) | Requires aid/equipment (please give details) | Details  (if struggling, please state) |
| **Bed** |  |  |  |  |  |
| **Chair** |  |  |  |  |  |
| **Toilet** |  |  |  |  |  |
| **Bath/Shower** |  |  |  |  |  |

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| **SELF-CARE/PERSONAL ACTIVITIES** | | | | |
| **If you currently have support with these activities (including using aids/equipment) please give details** | | | | |
|  | Independent | With aid/equipment | With physical assistance | Details (if struggling, please state) |
| **Washing** |  |  |  |  |
| **Dressing** |  |  |  |  |
| **Socks and Shoes** |  |  |  |  |
| **Cooking** |  |  |  |  |
| **Shopping** |  |  |  |  |
| **Laundry/Housework** |  |  |  |  |

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| **DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING** | | | |
|  | Yes | No | Details |
| **Package of Care** |  |  |  |
| **Call Bell** |  |  |  |
| **Telecare** |  |  |  |
| **Any other services** |  |  |  |

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| **FALLS**  **(provide details if yes)** | | |
|  | YES | NO |
| Have you had 1 or more falls in the past 6 months? |  |  |
| If you have had a fall, are you less able to do the things you used to do before your fall? |  |  |
| Have you had an unexplained fall or a fall as a result of losing consciousness dizziness? |  |  |
| Do you or your relative/carer worry you might have a fall? |  |  |
| Do you feel unsteady or have difficulties with walking or balance? |  |  |

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| **OTHER** | |
| Do you currently use any other aids/equipment to help you during your daily activities? |  |
| Do you currently work? |  |
| Do you drive? |  |

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| **ADDITIONAL COMMENTS** |
| **Please use this space to add any additional information that you feel is relevant** |
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| **MEASUREMENTS** | | |
| **Some patients may require toilet equipment after their operation so please provide the following measurements:** | | |
| **Calf Length Measurement** (cm/in) **\*\*\*** |  | |
| **Height** (feet/cm) |  | |
| **Weight** (lbs/stone/kg) |  | |
| **Toilet Height** (measure from top of the toilet bowl to the floor-not including the toilet seat) cm/in |  | |
| Please indicate if you are happy for us to order any equipment we feel you may need | **Yes** | **No** |

**\*\*\* To provide a calf length measurement**

Wear flat shoes

Sit on a chair with your knee at a right angle

Measure from the back of your knee to the floor

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| **SMALL DRESSING AIDS/EQUIPMENT** |
| If you are struggling with washing/dressing (putting socks and shoes on etc) you may find it useful to purchase some small dressing aids such as a long shoe-horn, grabber or sock aid. These are available online or in some chemists. |

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| **For office use only:**  **Screened by:**  **Date:** | |
| **Further input required** | **YES/NO** |
| **If yes, please give details:** |  |
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