Date of Request for this form: _____ Case No.: _____

Name: _____ IMM. No.: _____

ACTIVITIES OF DAILY LIVING (ADL)

1. Self-care	Intact (1) *	Limited (2) *	Helper (3) *	Unable (4) *
	(Note performance without help)		*(Note degree of assistance)*	
	With ease, no devices, no prior preparation	With difficulty, or with device, or prior preparation	Some help	Totally dependent
Preparing a meal	☐	☐	☐	☐
Feeding / Drinking	☐	☐	☐	☐
Managing medication	☐	☐	☐	☐
Dress Upper Body	☐	☐	☐	☐
Dress Lower Body	☐	☐	☐	☐
Don Braces/Prosthesis	☐	☐	☐	☐
Grooming	☐	☐	☐	☐
Wash / Bathe	☐	☐	☐	☐
Cleaning perineum (at toilet)	☐	☐	☐	☐

2. Sphincters Control	Complete	Complete with Urgency	Occasional Accidents	Frequent Accidents
	(Note control without help)		*(Note frequency of accidents)*	
	Complete, voluntary	Control, but with urgency, or use of catheter, appliance.	Occasionally some help needed.	Frequent or often wet/soiled
Bladder Control	☐	☐	☐	☐
Bowel Control	☐	☐	☐	☐

3. Mobility/ Locomotion	Intact (1) *	Limited (2) *	Helper (3) *	Unable (4) *
	(Note performance without help)		(Note degree of assitance)	
	With ease, no devices, no prior preparation	With difficulty, or with device, or prior preparation	Some help needed	Totally dependent
Able to stand	☐	☐	☐	☐
Transfer to bed/ chair/ wheelchair /toilet	☐	☐	☐	☐
Transfer to bath/ shower	☐	☐	☐	☐
Transfer to car	☐	☐	☐	☐
Walk 50 metres - Level	☐	☐	☐	☐
Stairs, Up/Down 1 Floor	☐	☐	☐	☐
Walk 50 metres (indoors or outdoors)	☐	☐	☐	☐
Cognitive/ mental capacity to go outdoors	☐	☐	☐	☐
Wheelchair 50 metres	☐	☐	☐	☐

4. Communication/ Engaging with other people.	Intact	Limited	Helper	Unable
Expression / speaking	☐	☐	☐	☐
Social Cognition	☐	☐	☐	☐
Social Interaction	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Ability to learn/ mental capacity	☐	☐	☐	☐
Visual capacity	☐	☐	☐	☐
Hearing	☐	☐	☐	☐

To be completed for children aged under 16 only:
Based on the child's disability or health condition, what additional needs does this child have compared to an avarage child of the same age?

Current Residence

☐ Own Home ☐ Relative's Home ☐ Other's (Specify) _____

☐ Personal Care Home ☐ Hospital

Current Care Giver

Name (Firstname LastName) _____

Relationship to Patient _____ Assistance to continue post arrival ☐ Yes ☐ No

Remarks