

Carers Self Directed Assessment

Please use the guidance leaflet to help you to complete this form.

This assessment document can either be completed and returned in the envelope provided (no stamp required) or if you would like any help to complete the form, please contact the Carers Centre on 0151 705 2307 and they will arrange for someone to help you.

The information that you provide will be treated in the strictest confidence and will only be held and used in accordance with the Data Protection Act 1998.

CARER DETAILS

Q1 Title

Mr Mrs Miss Ms

Other

Q2 First Name

Q3 Surname/ Last name/ family name:

Q4 Address

Q5 Postcode:

Q6 Date of Birth:

Q7 Home telephone number:

Q8 Mobile telephone number:

Q9 Email Address:

Q10 Preferred Communication method:

Letter Mobile phone
 Home phone Email

**Q11 NHS Number:
(10 digit number available from GP)**

This information is optional but by answering these questions you will help us to ensure that we are not discriminating against you or anyone else.

Q12 Gender/ sex:

Male Female Other Prefer not to say

Q13 Do you currently live in the gender you were given at birth?

Yes No Don't know Prefer not to say

Q14 Sexual Orientation

Heterosexual / straight Gay woman Asexual Other
 Gay man Bisexual Celibate Prefer not to say

Q15 Are you...

Married Civil partnership Single Other
 Cohabiting Divorced/ separated Widowed Prefer not to say

Q16 Religion

- | | | |
|--|---------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Hindu | <input type="checkbox"/> Sikh |
| <input type="checkbox"/> Christian (all denominations) | <input type="checkbox"/> Jewish | <input type="checkbox"/> Any other religion |
| <input type="checkbox"/> Buddhist | <input type="checkbox"/> Muslim | <input type="checkbox"/> Prefer not to say |

Q17 Do you consider yourself to have a long term illness, disability or health problem?

- Yes No Don't Know Prefer not to say

If yes, please describe below;

Q19 Are you pregnant or responsible for any children under the age of 18?

- Yes No Prefer not to say Don't know

How many? ..

Q20 Do any of the children you are responsible for have additional needs?

- Yes No

If yes, what needs?

Q22 Do you or the person you care for have any cultural, religious or gender related needs which we should consider in this assessment?

- Yes No

If yes, what needs?

Q24 In addition to your caring role, please tell us which of the following also applies to you?

- | | | |
|--|--|---|
| <input type="checkbox"/> Retired | <input type="checkbox"/> Self Employed | <input type="checkbox"/> Not in work (paid or unpaid) |
| <input type="checkbox"/> In paid work full time | <input type="checkbox"/> Student (Full time education or training) | <input type="checkbox"/> Looking after home/ family full time |
| <input type="checkbox"/> In paid work part-time (less than 30 hours) | <input type="checkbox"/> Voluntary (unpaid work) | <input type="checkbox"/> Other |

ETHNIC GROUP:

WHITE

- White British
 White Irish
 Traveller of Irish Heritage
 Gypsy/Roma
 Any other White background

MIXED

- White and Black Caribbean
 White and Black African
 White and Asian
 Any other Mixed background

ASIAN OR ASIAN BRITISH

- Indian
 Pakistani
 Bangladeshi
 Any other Asian background

BLACK OR BLACK BRITISH

- Caribbean
 African
 Any other Black background

OTHER / NOT STATED

- Chinese
 Any other ethnic group
 Prefer not to say

Details of person(s) cared for...

Q30 How many adults do you currently provide unpaid care for (not including children/ young people aged under 18)?

One Person

Two People

Three or more people

The following sections ask for information about the person(s) cared for, if the carer provides care for more than 3 people please complete for the 3 people they provide most care to.

CARED FOR PERSON 1

Q31 First Name:

Q35 Does this person live with you?

Yes (move to next section)

No (please complete address details below)

Q32 Surname:

Q36 Address

Q33 DOB

Q37 Postcode

Q34 Does this person live in permanent nursing, residential care or supported living?

Yes

No

CARED FOR PERSON 2

Q38 First Name:

Q42 Does this person live with you?

Yes (move to next section)

No (please complete address details below)

Q39 Surname:

Q43 Address

Q40 DOB

Q44 Postcode

Q41 Does this person live in permanent nursing, residential care or supported living?

Yes

No

CARED FOR PERSON 3

Q45 First Name:

Q49 Does this person live with you?

Yes (move to next section)

No (please complete address details below)

Q46 Surname:

Q50 Address

Q47 DOB

Q51 Postcode

Q48 Does this person live in nursing, residential care or supported living?

Yes

No

Please answer for each person cared for in the appropriate column (if there is more than 3 cared for people answer for the 3 people the carer provides most care to)

Q52 How long been caring for...

	<i>Person 1</i>	<i>Person 2</i>	<i>Person 3</i>
Less than 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 months- 2 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over 2 years but less than 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over 5 but less than 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over 10 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q53 Relationship of carer to person cared for...

	<i>Person 1</i>	<i>Person 2</i>	<i>Person 3</i>
Spouse/ partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your parent/ parent in law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your grandparent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child/ grandchild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another relative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your friend/ neighbour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q54 Please tick the box which is the primary or main need for each of the people you care for...

	<i>Person 1</i>	<i>Person 2</i>	<i>Person 3</i>
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frailty/ limited mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long term illness/ recovering from illness/ terminally ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/ AIDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse/ Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q55 Does the person(s) you care for receive support from social services, health or another organisation?

	<i>Yes</i>	<i>No</i>	<i>Dont Know</i>
Person 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YOUR CARING RESPONSIBILITIES

Q56 What tasks do you carry out as part of your caring role

- | | | |
|--|--|--|
| <input type="checkbox"/> Personal care | <input type="checkbox"/> Managing affairs/ help with bills, budgeting and finances | <input type="checkbox"/> Keeping an eye on them for their safety or well being |
| <input type="checkbox"/> Physical help eg lifting | <input type="checkbox"/> Prompting and motivating (any of the above) | <input type="checkbox"/> Emotional Support/ company |
| <input type="checkbox"/> Domestic and other practical help | <input type="checkbox"/> Provide transport | <input type="checkbox"/> Accompanying to appointments etc |
| <input type="checkbox"/> Assisting with medication | <input type="checkbox"/> Dealing with confusion / behavioural problems | <input type="checkbox"/> Other (please state below) |

Q57 Do you have any difficulty with any of the tasks you currently carry out?

- Yes (please describe below) No

Q58 Are you able and happy to continue undertaking these tasks?

- Yes No

Q59 Thinking about your personal safety, which of the statements best describes your present situation? By 'personal safety' we mean feeling safe from fear of abuse, being attacked or other physical harm.

- I have no worries about my personal safety I have some worries about my personal safety I am extremely worried about my personal safety

Q60 On average, how many hours of care do you estimate you provide over a week?

- 24 hours a day, 7 days a week
 50+ hours a week
 20-49 hours per week
 1-19 hours per week

Q62 Have you previously received a local authority service user or carer assessment including a telecare assessment or an assessment for equipment and / or adaptations?

- Yes No Don't know

Q63 If yes, please detail below...

Q61 On average, how many hours a week do you have to yourself as a result of the person(s) you care for receiving support from social care, voluntary organisations and or friends/ family?

Q64 Are you paid as a Personal Assistant (PA) through the Direct Payment of person you care for?

- Yes No Don't know

IMPACT OF CARING TO YOUR LIFE

Q65 In the last 12 months has your health been affected by your caring role in any of the ways listed below?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Feeling tired | <input type="checkbox"/> Disturbed sleep | <input type="checkbox"/> Short tempered/ irritable | <input type="checkbox"/> Made existing condition worse |
| <input type="checkbox"/> Feeling depressed | <input type="checkbox"/> General feelings of stress | <input type="checkbox"/> Had to see own GP | <input type="checkbox"/> Low self esteem |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Physical Strain (eg back pain) | <input type="checkbox"/> Developed own health condition | <input type="checkbox"/> Other (please give details below) |

Q66 Does your GP know you are a carer?

- Yes No Don't know

Q67 How is your health in general?

Very good

Good

Fair

Bad

Very bad

Q68 To what extent does caring impact on the following aspects of your life...

	<i>No Impact</i>	<i>Some Impact</i>	<i>Significant Impact</i>	<i>Serious Impact</i>
a) Health and wellbeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Ability to have a good nights sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Emotional well being and mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Choice and control over daily life / spending time how you want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Personal Care/ domestic routines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Opportunities to take part in work, education or learning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Ability to have time to yourself or to socialise / do things you value and enjoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Ability to maintain relationships with family and friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Your financial situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q69 If you have indicated that caring is having a significant or serious impact on any of the above statements, please provide details below...

Health and Wellbeing Scale

Q70 Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the past two weeks.

	<i>None of the time</i>	<i>Rarely</i>	<i>Some of the time</i>	<i>Often</i>	<i>All of the time</i>
I have been feeling optimistic about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling interested in other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've had energy to spare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been dealing with problems well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling close to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling confident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been able to make my own mind up about things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling loved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been interested in new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling cheerful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The above question is used to measure health and well being.

Warwick-Edinburgh Mental Well-being Scale (WEMWS)

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PLANNING YOUR SUPPORT

Q71 What would you like support to do?

- To find employment, education or training
- Help to juggle current employment, education or training with caring
- To learn more skills to help me to care ie lifting and handling training
- To look at ways to possibly reduce the hours of care that I currently provide
- To get more information about the condition of the person I care for
- To get benefits advice or help to manage finances
- To spend time doing things I value and enjoy, including socialising with others, taking part in community events / activities or getting time to myself.
- To maintain relationships with others and balance other social responsibilities such as family commitments with caring
- To improve my health and well being (or to change my lifestyle)
- To develop a plan for emergency situations
- To have peace of mind when I am out
- To find people I can talk to and discuss my feelings honestly
- Help to keep the house and garden clean and tidy
- Help to stay safe and warm in my home or to find suitable equipment/ adaptations to help me to carry out my caring role safely
- To participate or get involved in improving services
- Other (state below)

Thank you for taking the time to complete this self directed assessment. We will only share the information you have provided with the other organisations who need to know in order to provide you with a service. All information will be held in accordance with the Data Protection Act 1998.

Please sign and date the box below to confirm that the information contained in the form is correct to the best of your knowledge.

Q72 I the carer confirm that the information in this assessment is correct to the best of my knowledge. (Please sign and date below)

OFFICE USE SECTION

CARER ID

Carer SUIS/EPEX (If applicable)

Date Received:

SW Team

Carers FACs Band

SW Name/Contact

SU SUIS ID