**Social Connections**

(e.g. requirements whilst out in the community, socialisation skills etc.)

|  |
| --- |
|  |

**Cultural Needs**

|  |
| --- |
| **Are there any cultural aspects of the person’s life that need to be considered?** **How can GHS best support the cultural needs?** |

**Personal Preferences**

*(include carer preference)*

|  |
| --- |
| **Interests, Likes & Dislikes:** |

|  |
| --- |
| What is important to the client? |

|  |
| --- |
| **Characteristics of the people who support you best?** |

|  |
| --- |
| **Fears and anxieties**  |

## Living Arrangements

|  |
| --- |
|  |

## Behaviours of concern / Safety Considerations

|  |  |  |
| --- | --- | --- |
| **Does the client have a history of falls?***If yes, provide details* | [ ] **Yes** | [ ] **No** |
|  |
| **Does the client have a history of absconding?** *If yes, please indicate triggers for absconding in the box below:* | [ ] **Yes** | [ ] **No** |
|  |
| **Does the client have any behaviours of concern?** *Please tick where appropriate* | [ ] **Yes** | [ ] **No** |

|  |  |
| --- | --- |
| [ ] Self-Injury[ ] Pinching[ ] Hitting[ ] Pulling Hair[ ] Head-butting[ ] Banging | [ ] Kicking[ ] Screaming[ ] Biting[ ] Throwing Objects[ ] Obsessive Behaviours[ ] Other (Please detail below.....) |

|  |
| --- |
| **Please list any behaviour that may disrupt their day, have an impact on others or behaviours of concern.** |
| **Do they have a *Behaviour Support Plan (BSP)?*****If so please attach.** | [ ] **Yes** | [ ] **No** |
| **If yes, when was the last *Behaviour Support Plan* completed?** *Our Support Coordinator or Behaviour Support Manager will be in contact with you* |  |

**Eating and Nutrition** *(tick relevant boxes and provide details)*

|  |  |
| --- | --- |
| [ ] Eats independently  | Eating and nutrition details: |
| [ ] Requires assistance preparing meals  | Meal assistance details: |
| [ ] Uses utensils  | Utensil details: |
| [ ] Modified fluids | Modified food/ Fluid details: |
| [ ] Modified foods  |  |
| [ ] PEG (A feeding tube placed through the skin, into the stomach) |  |
| [ ] Swallowing impairment |  |
| [ ] Diet plan (e.g. special dietary requirements) / restrictions  | Like/Dislikes, Allergies: |
| [ ] Has a history of choking? (E.g. food, etc.) | Details: |

|  |
| --- |
| **Food preferences and dietary requirements**  |

**Any other information**

(Personal finances, Shift parameters, time, details, addresses etc.)

|  |
| --- |
|  |