

CLIENT ASSESSMENT FORM – DAY ACTIVITY CENTRE (CAF-DAC) (Adapted for parents)

Name: _____

IC No: _____

Centre: _____

Instructions: Please rate your **CHILD’S NEEDS** (ie “Client”) in the following areas based on:

- a. His or her respective day-day behaviour in the **PAST MONTH**.
- b. assumption that the client’s normal day-to-day environment adopts a **“LEAST RESTRICTIVE PRACTICE”** in the care approach towards the client.
- c. the “what” & NOT the “why” of behaviour

	Rating	<i>(please circle both rating & score)</i>	Client’s Needs (please tick if Client is rated B,C or D; more than one rating is possible)
Q1 MOBILITY	A	Requires no assistance	<input type="checkbox"/> Needs supervision, assistance or need instructions to move around <input type="checkbox"/> Needs supervision and physical guidance by staff in the use of assistive devices e.g., walking frame, quad stick or wheelchair <input type="checkbox"/> Needs pushing/positioning of wheelchair to meals/toilet/centre activities <input type="checkbox"/> Wheel chair bound - needs positioning/transfer from wheelchair to toilet commode/dining chair <input type="checkbox"/> _____
	B	Requires supervision (assistive device)/some physical assistance	
	C	Requires significant supervision (assistive device)/physical assistance	
	D	Totally dependent on parents/staff	
Q2 FEEDING	A	Requires no assistance	<input type="checkbox"/> Needs supervision because of poor ability to self-feed or messy eating <input type="checkbox"/> Needs positioning on chair <input type="checkbox"/> Needs assistance to cut up food into suitable portions at the dining table <input type="checkbox"/> Needs supervision to prevent choking / food grabbing from others at meal times <input type="checkbox"/> Needs assistance for refusal to eat due to withdrawn or depressed behaviour <input type="checkbox"/> Needs encouragement or assistance to feed self <input type="checkbox"/> _____
	B	Requires supervision/some physical assistance	
	C	Requires significant supervision/physical assistance	
	D	Totally dependent on parents/staff	

	Rating	(please circle both rating & score)	Client's Needs (please tick if patient/client is rated B,C or D; more than one rating is possible)
Q3 TOILETING (*excludes transferring client to wheelchair for toileting)	A	Requires no assistance	<input type="checkbox"/> Needs supervision to commence/complete toileting <input type="checkbox"/> Needs supervision /assistance in positioning over toilet receptacle <input type="checkbox"/> Needs assistance with undressing and dressing, clothing adjustments or change of clothes/diapers <input type="checkbox"/> Needs reminders/supervision to flush toilet after use <input type="checkbox"/> Needs reminders/supervision to clean self after toileting <input type="checkbox"/> Needs cleaning after episodes of incontinence <input type="checkbox"/> _____
	B	Requires supervision/some physical assistance	
	C	Requires significant assistance	
	D	Incontinent and/or totally dependent on parents/staff	
Q4 PERSONAL GROOMING & HYGIENE (*excludes cleaning/changing after incontinence)	A	Requires no assistance	<input type="checkbox"/> Needs constant reminders/assistance to be neat in attire <input type="checkbox"/> Needs constant reminders/assistance to wipe mouth after meals <input type="checkbox"/> Needs constant reminders to bathe <input type="checkbox"/> Needs supervision and assistance due to general self-neglect <input type="checkbox"/> Need supervision/assistance with selection of appropriate clothing <input type="checkbox"/> Need supervision/assistance with combing of hair <input type="checkbox"/> Need supervision/assistance with shaving <input type="checkbox"/> Need assistance with trimming of finger and toe nails <input type="checkbox"/> Need supervision/assistance with dressing, putting on slippers etc. <input type="checkbox"/> Need supervision/assistance with brushing of teeth, cleaning and fitting dentures and other oral care <input type="checkbox"/> Need supervision/assistance with sanitary napkins during menstruation <input type="checkbox"/> Needs supervision/assistance with soaping, washing, drying <input type="checkbox"/> _____
	B	Requires supervision/some assistance for grooming/hygiene activities	
	C	Requires significant assistance for grooming/hygiene activities	
	D	Totally dependent on parents/staff for all grooming & hygiene activities	

	Rating	(please circle both rating & score)	Client's Needs (please tick if patient/client is rated B,C or D; more than one rating is possible)
Q5 TREATMENT (*excludes psychological interventions)	A	No medical/nursing/ occupational therapy/ physiotherapy needs	<input type="checkbox"/> Supervised/assisted medication (oral/topical) and/or injection <input type="checkbox"/> Simple nursing procedure <input type="checkbox"/> Coaxing, prompting for medication/injection/ nursing/OT/PT refusal <input type="checkbox"/> OT/PT (please state whether the client requires individual or group session below) <input type="checkbox"/> Complex nursing procedure (please state the duration and frequency below) <input type="checkbox"/> _____
	B	Supervised/assisted medication and/or injection OR Simple nursing procedure	
	C	Supervised/assisted medication with coaxing required and/or injection with coaxing required OR Simple nursing procedure with coaxing required	
	D	Occupational/physiotherapy therapy OR Complex/specialised nursing procedure	
Q6 SOCIAL & EMOTIONAL NEEDS (*excludes needs associated with confusion, behavioural and/or psychiatric problems)	A	No evidence of need	<input type="checkbox"/> Encouragement to participate in home/DAC activities <input type="checkbox"/> Assurance to adjust to home/DAC routines <input type="checkbox"/> Support to families of clients <input type="checkbox"/> Comforting clients who are distressed <input type="checkbox"/> _____
	B	Occasional need (1-3 times a week)	
	C	Frequent need (4-6 times a week)	
	D	Always (Daily)	
Q7 CONFUSION - loses way - loses things - disorientated	A	No evidence	<input type="checkbox"/> Not oriented to place or person, (If the above prompt is <u>not</u> ticked, please rate an 'A' directly without considering the rest of the prompts) <input type="checkbox"/> Appear to be in their own world and may be agitated if given instructions <input type="checkbox"/> Restless, pacing up and down <input type="checkbox"/> Have repeated questions <input type="checkbox"/> Cannot recall immediate, recent or past events <input type="checkbox"/> Have episodes when possessions are lost <input type="checkbox"/> _____
	B	History of confusion in the past, but no such behaviour in past month	
	C	Occasional (1-3 times a week)	
	D	Often - Always (≥ 4 times a week)	

	Rating	(please circle both rating & score)	Client's Needs (please tick if patient/client is rated B,C or D; more than one rating is possible)
Q8 PSYCHIATRIC PROBLEMS (NO FORMAL DIAGNOSIS NEEDED)	A	No evidence of problem	<input type="checkbox"/> Hallucinations - hear and/or responds to voices <input type="checkbox"/> Delusions - is suspicious, accuses others of causing harm <input type="checkbox"/> Anxiety - anxious and tense - preoccupied with physical symptoms/ complaints <input type="checkbox"/> Depression - lacks interest in daily activities - tearful, easily upset - agitated <input type="checkbox"/> _____
	B	History of psychiatric problem(s) but no observable symptoms currently OR Some suspicion of underlying psychiatric problem(s)	
	C	Current mild interference in functioning (requires some supervision)	
	D	Current moderate - severe interference in functioning (requires medical/ psychological intervention)	
Q9a BEHAVIOURAL PROBLEMS - DISRUPTIVE BEHAVIOUR	A	No evidence of past/current disruptive behaviour	<input type="checkbox"/> Shouting, screaming <input type="checkbox"/> Tantrums, anger control problems, irritability <input type="checkbox"/> Hyperactivity, impulse control problems <input type="checkbox"/> Oppositional <input type="checkbox"/> Sexually disinhibited behaviour (e.g. Stripping, masturbation) <input type="checkbox"/> Absconding, wandering <input type="checkbox"/> Inappropriate speech/vocalisation <input type="checkbox"/> Inappropriate social behaviour <input type="checkbox"/> Other disruptive behaviour _____
	B	History of past disruptive behaviour but no current problem	
	C	Occasional (1-3 times a week) OR Mild level of disruptive behaviour (requires some supervision)	
	D	Often - Always (≥ 4 times a week) OR Moderate - Severe level of disruptive behaviour (requires medical/ psychological intervention)	

	Rating	(please circle both rating & score)	Client's Needs (please tick if patient/client is rated B,C or D; more than one rating is possible)
Q9b. BEHAVIOURAL PROBLEMS - STEREOTYPIC BEHAVIOUR	A	No evidence of past/current stereotypic behaviour	<input type="checkbox"/> Hand-flapping or waving <input type="checkbox"/> Head-rolling <input type="checkbox"/> Body-rocking <input type="checkbox"/> Spinning or flipping of objects <input type="checkbox"/> Sniffing objects <input type="checkbox"/> Repetitive hand or finger movements <input type="checkbox"/> Repetitive vocal sequences or screaming (if the behaviour is stereotypical and not rated under "Disruptive Behaviour") <input type="checkbox"/> Other stereotypic behaviour _____
	B	History of past stereotypic behaviour but no current problem	
	C	Occasional (1-3 times a week) OR Mild level of stereotypic behaviour (requires some supervision)	
	D	Often - Always (≥ 4 times a week) OR Moderate - Severe level of stereotypic behaviour (requires medical/ psychological intervention)	
*Q10a. RISK BEHAVIOURS - AGGRESSION	A	No evidence of past/current aggressive behaviour	<input type="checkbox"/> Verbal aggression <input type="checkbox"/> Property destruction <input type="checkbox"/> Body slamming <input type="checkbox"/> Physical aggression towards staff, strangers, other clients (e.g., punching, hitting, biting, kicking with body contact) <input type="checkbox"/> Sexual aggression or abusive behaviour <input type="checkbox"/> _____
	B	History of aggressive behaviour but no current problem	
	C	Occasional (1-3 times a week) OR Mild level of aggressive behaviour (requires some supervision)	
	D	Often - Always (≥ 4 times a week) OR Moderate - Severe level of aggressive behaviour (requires medical/psychological intervention)	
*Q10b RISK BEHAVIOURS - SELF INJURIOUS OR SUICIDAL BEHAVIOUR	A	No evidence of past/current self-harm or suicidal behaviour	<input type="checkbox"/> Self-mutilation (e.g. head banging, hair-pulling, skin-picking, self-biting, self-scratching) <input type="checkbox"/> Inserting fingers or objects into body orifices <input type="checkbox"/> Pica, extreme drinking <input type="checkbox"/> Intentional risk-taking and reckless behaviours <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Other self-harming behaviour _____
	B	History of self-harm/suicidal behaviour but no current problem	
	C	Occasional (1-3 times a week) OR Mild level of self-harm/ suicidal behaviour (requires some supervision)	
	D	Often - Always (≥ 4 times a week) OR Moderate - Severe level of self-harm/suicidal behaviour (requires medical/ psychological intervention)	

	Rating	(please circle both rating & score)	Client's Needs (Consider 'A' first, followed by 'B', 'C', then 'D'; only consider the next option if the earlier criteria wasn't met)
Q11a COMMUNITY LIVING NEEDS - TASK ORIENTATION	A	Independent	Must be able to focus attention & engage in repetitive tasks continuously for more than 1 hour, AND <input type="checkbox"/> Work on task without supervision <input type="checkbox"/> Work on task with minimum supervision <i>(tick at least 1)</i>
	B	Requires some supervision/assistance	Must be able to focus attention & engage in repetitive tasks continuously for ½ -1 hour, AND <input type="checkbox"/> Follow instructions <input type="checkbox"/> Respond to corrections <input type="checkbox"/> Ask for help <i>(tick at least 2)</i>
	C	Requires significant supervision/assistance	Must be able to focus attention & engage in repetitive task continuously for 10 - 30 minutes, AND <input type="checkbox"/> Follow instructions <input type="checkbox"/> Retrieve/keep task-related tools/materials <i>(tick at least 1)</i>
	D	Unable to engage	<input type="checkbox"/> Unable to focus attention & engage in repetitive task continuously for more than 10 minutes <input type="checkbox"/> Unable to follow instructions & retrieve/keep task-related tools/materials <i>(tick at least 1)</i>
Q11b COMMUNITY LIVING NEEDS - COMMUNICATION NEEDS (RECEPTIVE & EXPRESSIVE)	A	No communication needs	<u>RECEPTIVE</u> <input type="checkbox"/> Understand multi-step instructions <u>EXPRESSIVE</u> <input type="checkbox"/> Relate (verbal/non-verbal) experiences when asked <i>(tick all)</i>
	B	Low communication needs	<u>RECEPTIVE</u> <input type="checkbox"/> Understand 2-step instructions <u>EXPRESSIVE</u> <input type="checkbox"/> Ask (verbal/non-verbal) simple questions <input type="checkbox"/> Make request for things or for help <i>(tick 1 receptive & 1 expressive)</i>
	C	Moderate communication needs	<u>RECEPTIVE</u> <input type="checkbox"/> Understand 1-step instructions <u>EXPRESSIVE</u> <input type="checkbox"/> Indicate yes/no (verbal/non-verbal) to simple question <input type="checkbox"/> Protest against intrusions to personal space/desire <i>(tick at least 1)</i>
	D	Unable to communicate	<u>RECEPTIVE</u> <input type="checkbox"/> Unable to understand 1-step instructions <u>EXPRESSIVE</u> <input type="checkbox"/> Unable to indicate yes/no (verbal/non-verbal) to simple question <input type="checkbox"/> Unable to protest against intrusions to personal space/desire <i>(tick all)</i>

	Rating	(please circle both rating & score)	Client's Needs (Consider 'A' first, followed by 'B', 'C', then 'D'; only consider the next option if the earlier criteria wasn't met)
Q11c COMMUNITY LIVING NEEDS - TIME MANAGEMENT	A	No time management needs	<input type="checkbox"/> Follow timetable of daily routine without supervision <p style="text-align: right;"><i>(tick all)</i></p>
	B	Low time management needs	<input type="checkbox"/> Tell time, day, or date <input type="checkbox"/> Recognise and follow sequence of scheduled activities with/without prompting <p style="text-align: right;"><i>(tick all)</i></p>
	C	Moderate time management needs	<input type="checkbox"/> Follow sequence of scheduled activities only with prompting <p style="text-align: right;"><i>(tick all)</i></p>
	D	Totally dependent on staff	<input type="checkbox"/> Unable to follow the sequence of scheduled activities even with prompting <p style="text-align: right;"><i>(tick all)</i></p>
Q11 d COMMUNITY LIVING NEEDS - GETTING AROUND	A	Able to travel to familiar destinations by public/private transportation independently	<input type="checkbox"/> Use EZ link card (if applicable) <input type="checkbox"/> Recognise landmarks <input type="checkbox"/> Follow safety rules <input type="checkbox"/> Behave appropriately in public <p style="text-align: right;"><i>(tick all)</i></p>
	B	Requires supervision to travel to familiar destinations by public/private transportation	<input type="checkbox"/> Use EZ link card (if applicable) <input type="checkbox"/> Recognise landmarks <input type="checkbox"/> Follow safety rules <input type="checkbox"/> Behave appropriately in public <p style="text-align: right;"><i>(tick at least 2)</i></p>
	C	Requires supervision to travel to familiar destinations on foot/assistive device	<input type="checkbox"/> Recognise landmarks <input type="checkbox"/> Follow safety rules <input type="checkbox"/> Behave appropriately in public <p style="text-align: right;"><i>(tick at least 1)</i></p>
	D	Totally dependent on others to travel to familiar destinations on foot/assistive device	<input type="checkbox"/> Unable to recognise landmarks <input type="checkbox"/> Unable to follow safety rules <input type="checkbox"/> Unable to behave appropriately in public <p style="text-align: right;"><i>(tick all)</i></p>

	Rating	(please circle both rating & score)	Client's Needs (Consider 'A' first, followed by 'B', 'C', then 'D'; only consider the next option if the earlier criteria wasn't met)
Q11e COMMUNITY LIVING NEEDS - MANAGING \$	A	Able to handle cash independently	<input type="checkbox"/> Consider price when making a purchase <input type="checkbox"/> Receive correct change <input type="checkbox"/> Give appropriate amount when making payment <input type="checkbox"/> Store money for safekeeping <p style="text-align: right;"><i>(tick all)</i></p>
	B	Requires some supervision to handle cash on his/her behalf	<input type="checkbox"/> Consider price when making a purchase <input type="checkbox"/> Receive correct change <input type="checkbox"/> Give appropriate amount when making payment <input type="checkbox"/> Store money for safekeeping <p style="text-align: right;"><i>(tick at least 3)</i></p>
	C	Requires significant supervision to handle cash on his/her behalf	<input type="checkbox"/> Receive correct change <input type="checkbox"/> Wait to receive change <input type="checkbox"/> Give appropriate amount when making payment <input type="checkbox"/> Store money for safekeeping <p style="text-align: right;"><i>(tick at least 2)</i></p>
	D	Totally dependent on others to handle cash on his/her behalf	<input type="checkbox"/> No concept of money <input type="checkbox"/> Unable to handle money due to physical limitation <p style="text-align: right;"><i>(tick at least 1)</i></p>
Q11f COMMUNITY LIVING NEEDS - LEISURE/RECREATION	A	Able to engage in leisure/recreation activities without assistance/supervision	<input type="checkbox"/> Play board/card games or sports that require simple rules <input type="checkbox"/> Participate in outings and comply with both safety & conventional rules of etiquette <p style="text-align: right;"><i>(tick at least 1)</i></p>
	B	Able to engage in leisure/recreation activities with some assistance/supervision	<input type="checkbox"/> Play board/card games or sports that require simple rules <input type="checkbox"/> Participate in outings and comply with safety rules <input type="checkbox"/> Participate in outings and comply with conventional rules of etiquette <p style="text-align: right;"><i>(tick at least 1)</i></p>
	C	Able to engage in leisure/recreation activities with significant assistance/supervision	<input type="checkbox"/> Play board/card games or sports that require simple rules <input type="checkbox"/> Play board/card games or sports that have no rules / listen to music/watch television <input type="checkbox"/> Participate in outings with significant supervision <p style="text-align: right;"><i>(tick at least 1)</i></p>
	D	Unable to engage in any leisure/recreation activities even with significant supervision	<input type="checkbox"/> Unable to play any board/card games or sports, listen to music or watch television <input type="checkbox"/> Unable to participate in outings even with significant supervision <p style="text-align: right;"><i>(tick all)</i></p>

	Rating	(please circle both rating & score)	Client's Needs (Consider 'A' first, followed by 'B', 'C', then 'D'; only consider the next option if the earlier criteria wasn't met)
Q11g COMMUNITY LIVING NEEDS - SOCIAL FUNCTIONING	A	Able to interact socially without assistance/supervision	<input type="checkbox"/> Communicate with others (verbal/gestures) <input type="checkbox"/> Behave appropriately to others <input type="checkbox"/> Demonstrate appropriate level of physical contact <input type="checkbox"/> Participate in group activities <input type="checkbox"/> Wait for turn <input type="checkbox"/> Greet others (self-initiated/in response) <input type="checkbox"/> Respond to name <input type="checkbox"/> Tolerate proximity to others <p style="text-align: right;"><i>(tick all)</i></p>
	B	Able to interact socially with some supervision/training	<input type="checkbox"/> Communicate with others (verbal/gestures) <input type="checkbox"/> Behave appropriately to others <input type="checkbox"/> Demonstrate appropriate level of physical contact <input type="checkbox"/> Participate in group activities <input type="checkbox"/> Wait for turn <p style="text-align: right;"><i>(tick at least 3)</i></p>
	C	Able to interact socially with significant supervision/training	<input type="checkbox"/> Participate in group activities <input type="checkbox"/> Wait for turn <input type="checkbox"/> Greet others (self-initiated/in response) <input type="checkbox"/> Respond to name <input type="checkbox"/> Tolerate proximity to others <p style="text-align: right;"><i>(tick at least 2)</i></p>
	D	Unable to interact socially even with significant supervision	<input type="checkbox"/> Unable to participate in group activities <input type="checkbox"/> Unable to wait for turn <input type="checkbox"/> Unable to greet others (self-initiated/in response) <input type="checkbox"/> Unable to respond to name <input type="checkbox"/> Unable to tolerate proximity to others <p style="text-align: right;"><i>(tick at least 4)</i></p>

Name of staff completing Form: _____

Date: _____

Protocol

"I would like to discuss with you some of the needs of (Child's name) using a tool called the "Client-Assessment Form" (CAF). The CAF questionnaire helps us to understand the needs of (Child's name) in 3 areas :

1. Adaptive living skills (eg, feeding, mobility, toileting)
2. Community living skills (eg, do tasks independently or needs support, communication needs), and
3. Behaviours which will be important for our staff to take note of (eg, psychiatric issues, occasional aggressiveness) .

This will take around 20-30 minutes and we will go through the questionnaire together. Your input will help us to decide how best to support (Child's name), or if we are the best place for him/her. Do you have any questions you may want to ask about this questionnaire?"

Read the instructions line by line, and explain as required. Make sure they understand what their mindset should be when answering each question.

Go through each question with the parents.

For Q1-10b should be self-explanatory, and may just have to guide parents through each question.

For Q11a – 11g, will have to more closely run through with the parents as it's criterion based. Only go to next level of criterion if the previous level is met