Name : DOB: NHS/BC Number:

Health Needs Assessment

Name …………………………………………….	Address or current placement:
Male / Female ……………………………….	………………………………………………………
DOB: …………………………………………….	………………………………………………………
NHS Number ………………………………….. .	………………………………………………………

NOK / Representative…………………………..	GP……………………………………………………
Address…………………………………………….	Address…………………………………………….
………………………………………………………	………………………………………………………
Contact No……………………………………….	

Has consent for the assessment been obtained? Yes/No

(Please note that consent form must be completed before assessment commences and must accompany this document)

Is client subject to MHA Section 117 Aftercare? Yes/No

Medical History/Diagnosis

DO NOT COPY

Nurse Assessor: Date:

NHS

Midlands and Lancashire
Commissioning Support Unit

Name : DOB: NHS/BC Number:

Care Domain	**Registered nursing care needs and details of nursing provision or supervision necessary to help meet them**
Breathing	
Nutrition – food and drink	
Continence	
Skin	
Mobility	
Communication	
Psychological & Emotional Needs	
Cognition	
Behaviour	
Drug therapies and medication	
Altered states of consciousness	

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Nurse Assessor: Date:

Name : DOB: NHS/BC Number:

Other significant care needs	

In your opinion can the patient's best needs be met in: (indicate one only)

Own home with a package of care and community nurse input ☐

Residential/EMD Home (delete as appropriate) with community nurse input ☐

Nursing Home/EMI placement (24 hour RN/RMN on site) ☐

Rationale for above placement decision

DO NOT COPY

Signature of nurse completing the form: ____________________

Professional qualification: ____________________

Date completed: ____________________