

DIAG PERSONAL HANDLING RISK ASSESSMENT

Client Name: DOB: Address:	Place of Assessment: Height: Weight:
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With the service user, please consider by ticking and commenting, where appropriate if any of the following factors need to be taken into account, when assistance to move is required.

Assessment No:	Fully Independent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="checkbox"/> 1. Communication <input type="checkbox"/> 2. Comprehension <input type="checkbox"/> 3. Sight/hearing <input type="checkbox"/> 4. Appropriate behaviour <input type="checkbox"/> 5. History of falls/seizures <input type="checkbox"/> 6. Medication	<input type="checkbox"/> 7. Sitting balance <input type="checkbox"/> 8. Sitting to stand <input type="checkbox"/> 9. Weight-bearing <input type="checkbox"/> 10. Walking <input type="checkbox"/> 11. Upper limb strength <input type="checkbox"/> 12. Head control	<input type="checkbox"/> 13. Range of joint movement <input type="checkbox"/> 14. Muscle power/tone <input type="checkbox"/> 15. Involuntary movement <input type="checkbox"/> 16. Supports attachments <input type="checkbox"/> 17. Pain <input type="checkbox"/> 18. Skin condition <input type="checkbox"/> 19. Other	
Comments:			
People involved in the assessment:			
Assessors Name		Assessors Designation	
Assessors Signature		Date of Assessment	

Service Users Name:	
Assessment Criteria:	Assessment No:
	Date:
SIT/STAND	Not applicable <input type="checkbox"/>
• Independent?	Yes <input type="checkbox"/> No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment	
• Method	
• Variance	Yes <input type="checkbox"/> No <input type="checkbox"/>
SIT/SIT	Not applicable <input type="checkbox"/>
• Independent?	Yes <input type="checkbox"/> No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment	
• Method	
• Variance	Yes <input type="checkbox"/> No <input type="checkbox"/>
ASSISTANCE TO USE THE TOILET	Not applicable <input type="checkbox"/>
• Independent?	Yes <input type="checkbox"/> No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment	
• Method	
• Variance	Yes <input type="checkbox"/> No <input type="checkbox"/>
WALKING	Not applicable <input type="checkbox"/>
• Independent?	Yes <input type="checkbox"/> No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment	
• Method	
• Variance	Yes <input type="checkbox"/> No <input type="checkbox"/>
MOVING UP/DOWN BED	Not applicable <input type="checkbox"/>
• Independent?	Yes <input type="checkbox"/> No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment	
• Method	
• Variance	Yes <input type="checkbox"/> No <input type="checkbox"/>
TURNING IN BED	Not applicable <input type="checkbox"/>

• Independent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment		
• Method		
• Variance	Yes <input type="checkbox"/> No <input type="checkbox"/>	
IN/OUT BED	Not applicable <input type="checkbox"/>	
• Independent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment		
• Method		
• Variance	Yes <input type="checkbox"/> No <input type="checkbox"/>	
BATHING/SHOWERING	Not applicable <input type="checkbox"/>	
• Independent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment		
• Method		
• Variance	Yes <input type="checkbox"/> No <input type="checkbox"/>	
FIRE EVACUATION	Not applicable <input type="checkbox"/>	
• Independent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment		
• Method		
FALLS	Not applicable <input type="checkbox"/>	
• Independent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• No. Carers	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
• Equipment		
• Method		

TASK <input type="checkbox"/>		Not applicable <input type="checkbox"/>			
• Independent?		Yes <input type="checkbox"/>		No <input type="checkbox"/>	
• No. Carers		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>			
• Equipment					
• Method					
• Variance		Yes <input type="checkbox"/> No <input type="checkbox"/>			
TASK <input type="checkbox"/>		Not applicable <input type="checkbox"/>			
• Independent?		Yes <input type="checkbox"/>		No <input type="checkbox"/>	
• No. Carers		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>			
• Equipment					
• Method					
• Variance		Yes <input type="checkbox"/> No <input type="checkbox"/>			
TASK <input type="checkbox"/>		Not applicable <input type="checkbox"/>			
• Independent?		Yes <input type="checkbox"/>		No <input type="checkbox"/>	
• No. Carers		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>			
• Equipment					
• Method					
• Variance		Yes <input type="checkbox"/> No <input type="checkbox"/>			

HOIST DETAILS			
HOIST DETAILS	Make		
	Model		
	Type	Mobile <input type="checkbox"/>	Fixed <input type="checkbox"/>
	(Tick)	Standing <input type="checkbox"/>	Gantry <input type="checkbox"/>
SLING DETAILS	Type	Explain loop or clip arrangement:	
	Size e.g. S, M, L, XL, XXL		
HOIST DETAILS			
HOIST DETAILS	Make		
	Model		
	Type	Mobile <input type="checkbox"/>	Fixed <input type="checkbox"/>
	(Tick)	Standing <input type="checkbox"/>	Gantry <input type="checkbox"/>
SLING DETAILS	Type	Explain loop or clip arrangement:	
	Size e.g. S, M, L, XL, XXL		

Assessor Name	Designation	Signature	Date