REPUBLIC OF KENYA

MINISTRY OF HEALTH

Ref: MOH/276A

ASSESSMENT FORM FOR PHYSICAL DISABILITIES

Name of Health Facility:		Date:	DD	MM	YYYY

Applicant Information for the purpose of reporting on Disability Assessment:

Name:			ID No.		Gender:	
Date of Birth: Age:	DD / MM / YYYY	Occupation:		Phone No.		
County:		Sub-County:		Marital Status:		

Next of Kin Details:

Name:		Relation:		Phone No.	

Assembled Medical Team details:

MEMBERS	NAME	REG. NO.	SIGNATURE	Health Facility Official Stamp
Chairperson				
Member				
Member				
Member				

(***I understand that giving false information is punishable by the laws of Kenya)***

Note: the committee should have a minimum of three Members

SUMMARY FINDINGS

Brief Medical History	
Date of Injury/Onset of Illness	
Date of Last Intervention	
Cause of Disability	

STRUCTURAL IMPAIRMENTS

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s7. STRUCTURE: (Tick Region/part being assessed that has IMPAIREMENT)

s710 Head and neck region

s720 Shoulder region

s730 Upper extremity (arm, hand)

s740 Pelvis

s750 Lower extremity (leg, foot)

s760 Trunk

s8. SKIN AND RELATED STRUCTURES ANY OTHER BODY STRUCTURES

REGION (s) AFFECTED

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Assessment Area	Findings	Score √ for nature of impairments					Remarks
		No Impairment	Mild Impairment	Moderate Impairment	Severe Impairment	Compete Impairment	
Muscle Power of affected muscle groups							
Range of motion of joints affected							
Degree of structural angulation /deviation							
Level of limb Amputation							
Bilateral Lower Limb Length							
Balance and coordination							
Other Physical Impairments (Specify)							
SCORE FOR IMPAIRMENTS							

FUNCTION AND PARTICIPATION RESTRICTIONS

Area	Score √ For Nature of Difficulty					Remarks
	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Complete Difficulty	
Mobility						
Self-Care						
Domestic Life						
Major Life Areas						
Community, Social, Civic Life						
Score For Function and Participation Restriction						

Disability Rating

No disability	
Mild	
Moderate	
Severe	
Complete	

CONCLUSION

TEMPORARY ☐ PERMANENT ☐

RECOMMENDED ASSISTIVE PRODUCT(S).....

OTHER REQUIRED SERVICES.....

VERIFIED BY THE COUNTY DIRECTOR OF HEALTH

Name.....

Date .....

Signature.....

COUNTY DIRECTOR OF HEALTH OFFICIAL STAMP