# REPUBLIC OF KENYA

## MINISTRY OF HEALTH

**Ref: MOH/276E**

### ASSESSMENT FORM FOR MENTAL/ INTELLECTUAL/ AUTISM SPECTRUM DISORDERS

| 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:<br>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*

**BRIEF CLINICAL HISTORY (Past and Present Medical History)**

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**Mental Status Evaluation**

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**Complete the Assessment Tool Below by Scoring Appropriately**

***Knows how and when to feed, toilet or groom self***

| **Feeding** | **Toileting** | **Grooming** |
|---|---|---|
| ❑ 0.0 Completely Independent | ❑ 0.0 Completely Independent | ❑ 0.0 Completely Independent |
| ❑ 1.0 Partial | ❑ 1.0 Partial | ❑ 1.0 Partial |
| ❑ 2.0 Minimal | ❑ 2.0 Minimal | ❑ 2.0 Minimal |
| ❑ 3.0 None (Dependent) | ❑ 3.0 None (Dependent) | ❑ 3.0 None (Dependent) |

| **Dependence on Others** | | **Psychosocial Adaptability** |
|---|---|---|
| **Level of Functioning** | | **Employability/ Schooling** |
| ***Physical &cognitive disability*** | | ***As full-time worker, homemaker, student*** |
| 0.0 | Completely Independent | 0.0 Not Restricted |
| 1.0 | Independent in special environment | 1.0 Selected jobs, competitive |
| 2.0 | Mildly Dependent-Limited assistance | 2.0 Sheltered workshop, Non-competitive. |
| 3.0 | Moderately Dependent-moderate assist *by Person in home* | 3.0 Not Employable/ not in school |
| 4.0 | Markedly Dependent Assistance with all major activities, all times | |
| 5.0 | Totally Dependent | |
| **Total Disability Rating Score (Sum of all Scores)** | | **=** |

**Scoring Key:**

| Total DR Score | Level of Disability |
|---|---|
| **0** | None |
| **1 - 4** | Mild |
| **5 - 8** | Moderate |
| **9 - 12** | Severe |
| **13 - 17** | Very Severe |

**Conclusion:**

Duration of Illness: **.....**

Major Cause of Disability: **.....**

Level of Disability: **.....**

**RECOMMENDED ASSISTIVE PRODUCT(S).**.....

**OTHER REQUIRED SERVICES**.....

**VERIFIED BY THE COUNTY DIRECTOR OF HEALTH**

**Name**.....

**Date** .....

**Signature**.....

**COUNTY DIRECTOR OF HEALTH OFFICIAL STAMP**