REPUBLIC OF KENYA

MINISTRY OF HEALTH

Ref: MOH/276G

ASSESSMENT FORM FOR PROGRESSIVE CHRONIC 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: 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

Medical History (brief)	
Date of Injury/Onset of Illness	
Date of Last Intervention	
List Past and Ongoing Interventions	
Cause of Disability	

STRUCTURAL IMPAIRMENTS

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....

REGION (s) AFFECTED

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....
....

Assessment Area	Findings /diagnostic tests Imaging (MRIs, CT) Labs tests, 6 minutes' walk test, Pulmonary function test (PFTs), MMT, ROM, Echocardiogram (EEG), Visual analog pain scale, Berg balance scale, TUG, Tinetti, lower extremity functional tests, cognitive tests, Speech and swallowing tests	Score √ For Nature of Impairments					Remarks
		No Impairment	Mild Impairment	Moderate Impairment	Severe Impairment	Compete Impairment	
Cardiopulmonary/ Cardiovascular							
Respiratory							
Malignancies/ Cancer							
Musculoskeletal							
Neurological							
Gastro-intestinal disorders							
Dermatological							

Hematologic system							
Vascular conditions							
Genito - urinary							
Frailty							
Other							

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 SERVICES REQUIRED ....

VERIFIED BY THE COUNTY DIRECTOR OF HEALTH

Name...

Date ....

Signature...

COUNTY DIRECTOR OF HEALTH OFFICIAL STAMP