Name of Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Setting of assessment (home, work, recreation, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This assessment is to be completed by a person who knows the individual well and, when possible, with a second observer present. Assess the individual’s knowledge and skills in each environment where medication(s) is taken. *Persons conducting this assessment will need to have ALL necessary information regarding current inhaled medications including medication name(s), dose(s), route(s), time(s), purpose for medication(s), parameters, and basic side effects. In addition, the person completing the assessment must know how to use and maintain the type of medication delivery system used by the individual. Complete this form (pages 1-2) in its entirety regardless of answers.*** (See *Introduction-Instruction Self-Administration Assessment* for more information)

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**1. Recognizes medication by color, size, packaging and/or by reading the label. (i.e., can read label or will ask for help or will**

**confirm with someone else).**

**Yes**  Continue to #2  **No**  Unable to Self-Administer With or Without Assistance. Continue to #2

**2. Knows what medication is for (i.e., make breathing easier, wheezing).**

**Yes**  Continue to #3 **No**  Unable to Self-Administer With or Without Assistance. Continue to #3

**3. Knows and recognizes how much medication to take (i.e., 1 puff, 1 dose, 1 ampule).**

**Yes**  Continue to #4 **No**  Unable to Self-Administer With or Without Assistance. Continue to #4

**4. Knows proper technique for taking medication (i.e. shake canister, exhale prior to administration, use spacer, using nebulizer).**

**Yes**  Continue to #5 **No**  Unable to Self-Administer With or Without Assistance. Continue to #5

**5 Recognizes when not feeling well; knows who to tell and will tell them. (i.e., tremor, hoarse voice, distress).**

**Yes**  Continue to #6 **No**  Unable to Self-Administer With or Without Assistance. Continue to #6

**6. Knows when a refill is needed so medication never runs out (i.e., 4-7 days of medication left). Knows who to tell to get refill when needed; will seek assistance if needed for refill or if medication is not available.**

**Yes**  Continue to #7 **No**  Unable to Self-Administer With or Without Assistance. Continue to #7

**7. Knows who to ask/tell when there is a problem with medication (i.e., canister doesn’t look right, runs out of medication). Will not take medication and will notify that person immediately.**

**Yes**  Continue to #8 **No**  Unable to Self-Administer With or Without Assistance. Continue to #8

**8. Knows when to take medication. (**i.e., by time, by feeling**). Has demonstrated ability to take medication at the right time/day by using a clock, routine or symptoms (**i.e., before breakfast, wheezing, shortness of breath**).**

**Yes**  Continue to #9 **No**  If able to self-administer (questions 1-7 = “Yes”; outcome = “Self-administration with Assistance”), the service plan will include need for reminder assistance. Continue to #9

**9. Knows how to clean and store equipment.**

**Yes**  Continue to #10 **No**  If able to self-administer (questions 1-7 = “Yes”; outcome = “Self-Administration with Assistance”), the service plan will include need for assistance for cleaning and storage. Continue to #10

**10. Able to get medication to and from storage.**

**Yes**  Continue to #11 **No** If able to self-administer (questions 1-7 = “Yes”; outcome = “Self-Administration with Assistance”), the service plan will include need for physical assistance for storage. Continue to #11 (on page 2)

**11. Able to assemble medication delivery device, press on canister base, load dry medicine, get mouthpiece to mouth; or knows what to do but is not physically able.**

**Yes**  If “Yes” to all eleven questions, able to Self-Administer Without Assistance **No** If able to self-administer (questions 1-7 = “Yes”; outcome = “Self-Administration with Assistance”), the service plan will include need for physical assistance for assembly or any step of the process.

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**Record Assessment Outcome below**

**Assessment Outcome:**

The individual service plan (ISP) must indicate the outcome of the assessment and how medications will be administered (assessment outcome plus supports if needed). Based on all answers to questions 1-11, choose one of the outcomes listed below:

Able to “self-administer” without assistance (Questions 1 through 11 are all “Yes”)

Able to “self-administer” with assistance (Questions 1 through 7 are “Yes”; any one or all of 8 through 11 are “No”). OAC 5123:2-6-02 specifies the three types of assistance that can be provided by **uncertified** personnel. Indicate below the type or types of assistance that apply. Provide specific instruction in the individual’s ISP.

1. The individual receives assistance with self-administration of medication through reminders of when to administer the medication and/or confirm directions on the container.

2. The individual receives assistance with medication administration by removing medication from storage area.

3. Upon request or with consent, and at the individual’s direction, provide physical assistance with any step of the process.

Unable to self-administer with or without one of the three types of assistance (the answer is “No” to any one or all of questions 1-7). Choose one of the following:

The individual can do some steps of medication administration and a properly licensed or certified and authorized person completes the other steps of medication administration. (List details in ISP).

A properly licensed or certified and authorized person must administer medication.

**Other Considerations:**

Because of demonstrated and documented unsafe behaviors, the individual is unable to safely self-administer with or without assistance. If yes, according to rule (Ohio Administrative Code 5123:2-2-06, Behavior Support Strategies that include Restrictive Measures), this must be addressed as a rights restriction in the ISP. Brief summary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The individual has oral, topical medications or specific health care tasks. Use the specific Self-Administration Assessment for Medication - oral/topical, Oxygen, Glucometer and/or Health Care Tasks to determine level of independence, assistance or supports needed.

*The Self-Administration Assessment must be completed at a minimum of every 3 years, with a review completed* *annually.*

**Annual Review; the confirmation of no changes**

**First Review:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Signature & Title of Person Performing Assessment Date

**Second Review:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Signature & Title of Person Performing Assessment Date