



ALIGNING INTERPROFESSIONAL EDUCATION AND COLLABORATION IN PRACTICE

using promising regional experiences for international exchange

ICF IN PERSON-CENTRED REHABILITATION

Material to support the interprofessional implementation

The International Classification of Functioning, Disability and Health (ICF) is a linking framework for interprofessional collaboration and structuring the needs of a client. The person's functioning is the starting point for person- and goal-oriented iterative rehabilitation, for which ICF applications are needed.

The objective of this material is to support the use of the ICF in person-centred rehabilitation and in interprofessional practice by offering ICF tools.

It is based on MAGPIED rehabilitation process: Meet, Assess, Goal set, Plan, Implement, Evaluate and Document. Even though the material follows the rehabilitation model, it can be used by any professionals who uses the ICF. The idea of the material is to offer a short theoretical background, examples and tools as well as examples of assignments for the reader.

It can be used by any professionals as an inspiring package of ICF tools or supporting material when educating the usage of ICF in higher education institutions. For the lectures the material includes supplement power point presentation for Assess and Plan phases.

Authors

Jaana Paltamaa, Adjunct professor, PhD, pt, Jamk University of Applied Sciences, Finland

Anu Myllyharju-Puikkonen, Senior Lecturer, Jamk University of Applied Sciences, Finland

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- AP University of Applied Sciences and Arts Antwerp, Belgium
- Coronaria Rehabilitation and therapy services (Coronaria Contextia Ltd), Finland
- Hanze University of Applied Sciences, Groningen, The Netherlands
- Jamk University of Applied Sciences, Jyväskylä, Finland
- Moorheilbad Harbach Gesundheits- & Rehabilitationszentrum, Austria
- Rehabilitation Centre Revalidatie Friesland, The Netherlands
- St. Poelten University of Applied Sciences, Austria

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INTRODUCTION

The purpose of the material

The purpose is to provide material, tools and approaches based on the International Classification of Functioning, Disability and Health (ICF) to implement the ICF for any social or health professional, student or lecturer. You can benefit from the material even if you do not belong to any of the above groups. The material can be used as a tool for self-learning or as a tool for teachers or workplace supervisor familiar with the ICF framework when planning ICF education or implementation.

This material is developed for the continuum of ICF education, within the Erasmus + INPRO (Interprofessionalism in Action) -project 2022-2023 by Jamk University of Applied Sciences with INPRO consortium. This document is the result of a development process and has been developed based on feedback from the international INPRO pilots and focus group discussion.

Learning requirements

An understanding of the basics of ICF (ICF model, structure and codes) is recommended in order to better understand the contents of this document. For example, to undergo ICF training in your country, study the [INPRO ICF Basic Course](#) or the [ICF e-learning Tool](#) developed by the WHO-FIC Education and Implementation Committee (EIC) and the Functioning Disability Reference Group (FDRG). Clinical experience with the ICF is also an advantage.

It is important that you have a HEI teacher or a social and health workplace supervisor who has agreed to support in your study. Regular clinical supervision during the course of your study should also assist you to stay on track, provide opportunities for your supervisor to monitor your progress, provide encouragement, and to check that you understand the information in the learning materials.

Activities and assignments may require access to the internet.

Learning outcomes

After reading this material, you should be better able to apply the ICF in person-centred and interprofessional practices.

This material will improve your ICF related learning outcomes in interprofessional competences ([INPRO Competence Framework 2023](#).)

- Interprofessional Practise - IPC1. Places the person and their family at the centre of the interprofessional practice.
- Interprofessional Practise - IPC4. Adopts a sustainable interprofessional approach to problem-solving and decision-making.
- Learning and Development - LDC1. Continues to learn and develop in interprofessionalism.
- Management and Leadership - MLC3. Acts as an interprofessionalism advocate.
- Research - RC2. Works to strengthen evidence for interprofessional rehabilitation.

Overview of the content and how to use the material

It is important to develop an empirical basis for the selection of education methods for target groups and specific purposes (Reed et al. 2008). The need to develop "ICF IN PERSON-CENTRED REHABILITATION - Material to support the interprofessional implementation" - material arose from the needs of clinical practice - how to apply the ICF in practice. This material is based on a person-centred, interprofessional rehabilitation process. The focus is on assessing functioning and setting goals, after which the professional can implement the intervention agreed with the client and the interprofessional team.

The material consists of five (6) different chapters:

1. Rehabilitation process
2. Meet phase
3. Assess phase
4. Goal-set – Plan phases
5. Implement – Evaluate phases
6. Document phase

Each chapter contains theoretical background, examples, tools and approaches, and examples of assignments to help you practice using the ICF. If the material is used by lectures, additional assignments made by the lecture can be used. A list of references can be found at the end of the document. The terminology used in the material is described in the glossary of terms.

The term 'person' is used throughout this material even since interchangeably a term 'client' and 'patient' can be used due to the varied environments in which social and health care is carried out. It includes also the 'family' of the person. Please use your organisation's preferred term when performing your assignments.



The term "professional" is always used when referring to a professional using the ICF, regardless of profession.

Chapter 3 of the [WHO-FIC ICF e-Learning Tool](#) introduce the additional areas of ICF application providing examples from Brazil, Mexico, Germany and Switzerland.



Symbols

The following symbols are used throughout this material.

- The note, example, etc



- Video



- Assignment



CONTENT

1. Rehabilitation process – MAGPIED-model

Learning objective

- To sketch how rehabilitation process described by MAGPIED model is organised and structured

At least one in every three people in the world needs rehabilitation at some point during the course of their disease or injury (Cieza et al, 2021 World Health Organization, 2023a). Rehabilitation is not only for people with disabilities or long-term impairments. Rather, rehabilitation is an essential health service for anyone with an acute or chronic health condition, impairment or injury that limits functioning. The main goal is to ensure that people with a health condition can remain as independent as possible and participate in education, work and meaningful life roles and to reduce their experience of disability. Rehabilitation is defined as a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment. (World Health Organization, 2023a.)

Functioning is the starting point of a client and goal oriented iterative rehabilitation problem-solving process (Cieza & Stucki, 2005a Rauch et al., 2008). It involves several steps, as described in the Wade (2005) and the Health Queensland (2017) models, among others. They are informed by the ICF framework and underpinned by principles of client-centred goal setting, interprofessional collaboration, and holistic care.

The MAGPIE model is based on the Wade's model (Wade, 2005) and was developed by a team of health professionals working in Australian community rehabilitation settings as part of a workforce redesign project (Health Queensland, 2017). The MAGPIE acronym stands for the following clinical team functions: **U**meet, **A**ssess, **G**oal-Set, **P**lan, **I**mplement and **E**valuate. The MAGPIE model lacks documentation, so for the INPRO project we use a modified model called MAGPIED (Figure 1) where the letter **D** stands for **D**ocumentation.

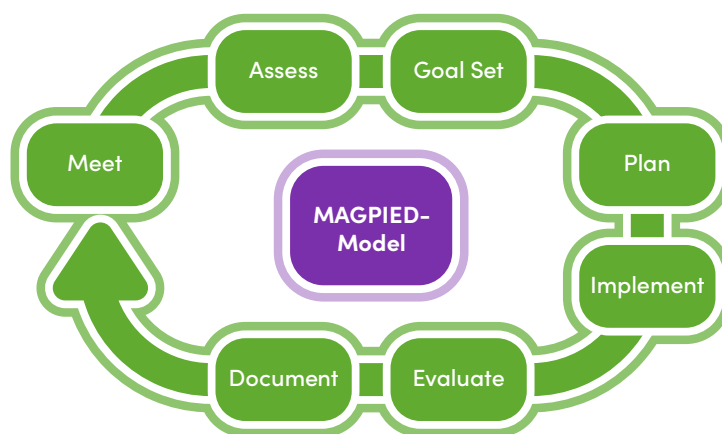


Figure 1. MAGPIED rehabilitation process (modified from Wade (2005) and the Health Queensland (2017) models).

The MAGPIE model describes a process to support interprofessional team-based case management. It has since been adapted by health educators as a framework for interprofessional education. It also outlined some of the learning activities that can be designed using the MAGPIE model (Moran et al., 2020, 7, Table 2).

According to the Wade (2020) the important features that characterize effective rehabilitation (Figure 2) are as follows:

- Basing the process on the biopsychosocial model of illness.
- Having an expert multidisciplinary team, which uses structured protocols to ensure a consistent, comprehensive approach.
- Undertaking a comprehensive (holistic) initial (diagnostic) assessment to achieve a full understanding of the patient's situation, both the factors that influence it and the factors that may determine interventions.
- Using many different interventions tailored to the particular client.
- Monitoring the changes arising in association with these interventions, evaluating them against goals, and checking for potential harms.

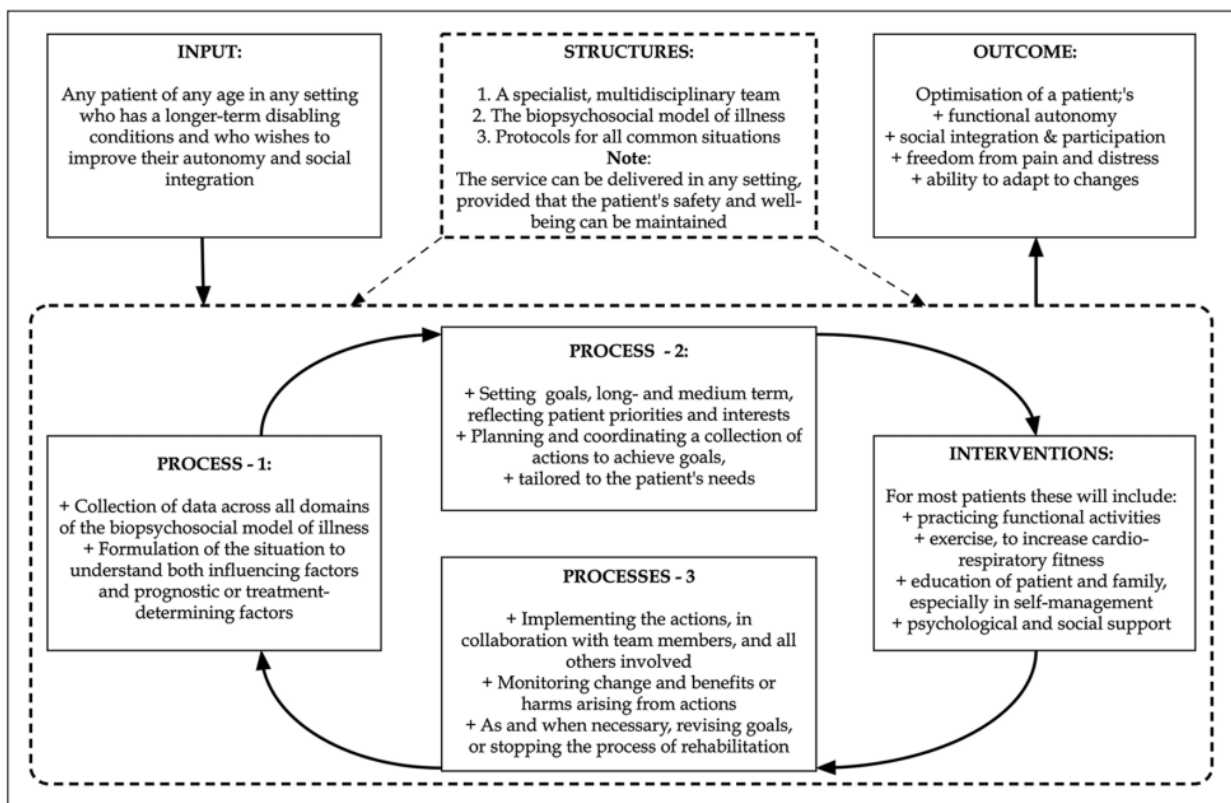
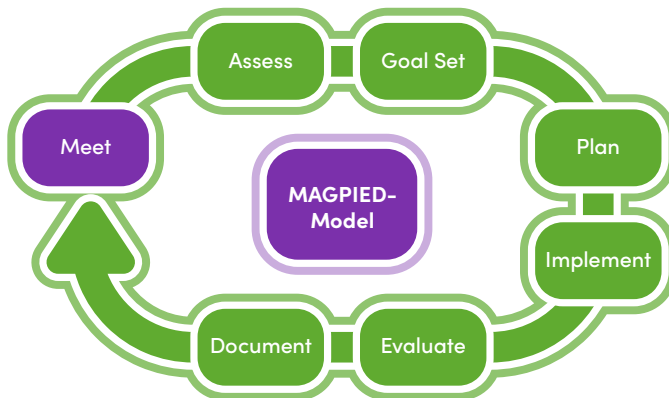


Figure 2. Rehabilitation: who benefits, what structures are needed, what processes occur, and what is the outcome? (Wade 2020, 580)

2. Meet



Learning objectives.

- To describe ICF as a person-centred framework
- To describe ICF as an interprofessional framework
- To consider ethical aspects of using the ICF framework

The rehabilitation starts when facing the person for the very first time. The focus is on person-centred and interprofessional approach for functioning. The meet phase includes (Moran et al 2020):

- Establish rapport with a person
- Identify cultural factors
- Explain service and team roles
- Gain consent (for example to share information within the interdisciplinary team)

2.1. Person-centred approach and ICFF

Person-centred approach emphasizes the importance of the reciprocity of communication with the person or client (McCance et al 2016). Person centredness is based on shared responsibility, collaboration, and holistic view of the human being, acting in a social context according to his or her preferences or goals (Mills 2017). The translation of person-centred care concepts into practice requires fulfilment of necessary components (Table 1) (Balqis-Ali et al., 2022).

Table 1. The central constructs of the person-centred practice framework (modified from Balqis-Ali et al., 2022).

Prerequisites	Characteristics of rehabilitation professionals include professional competence, developed interpersonal skills, commitment to work, ability to demonstrate clarity of beliefs and values, and self-awareness.
The care environment	The environment in which rehabilitation takes place includes factors such as: an appropriate mix of skills, systems that facilitate shared decision-making, effective staff relations, supportive organizational systems, power-sharing, opportunities for innovation and risk-taking, and the physical environment..
Person-centred processes	Rehabilitation delivery through various activities, including working with person's beliefs and values, engagement, sympathetic presence, sharing decision making, and providing holistic care.
Person-centred outcomes	As a result of effective, person-centred rehabilitation, clients are satisfied with their rehabilitation, they have been active participants in their own rehabilitation, and they are feeling wellbeing.

McMurray (1995) highlights the importance of transparency of values reflecting behaviours and actions and ultimately in being authentic in work that focus on person-centredness. Professionals need to be aware of 'self' and how their own values and beliefs can impact on decisions made about a person's care and treatment. This reinforces the centrality of shared decision-making in health care and the need for a 'negotiated' approach between practitioner and the person receiving care. (McCormack & McCance, 2016.) McCormack and McCance (2016) defines person-centred practice as an approach based on building and nurturing healthy relationships between all care providers, service users and other people who matter in their lives. It is underpinned by values of respect for persons, individual autonomy, mutual respect and understanding.

A practical manual for using the ICF recommends that from a person-centred perspective, validity and ethical reason, it is important to involve the person in the centre of rehabilitation during the whole process, even though many professionals and family members have also their viewpoint on the functioning and disability (World Health Organization 2013, 16). ICF offers a comprehensive framework to describe the different aspects of the person's life, functioning and disability (World Health Organization 2001).

By following the ethical guidelines of the ICF the professionals will be guided towards a person-centred approach respectful of cultural diversities (World Health Organization 2001, 244-245; 2013, 15).

2.2. ICF in interprofessional collaboration

Practical synergies between ICF and Interprofessional Education and Collaborative Practice (IPECP) will enable ICF to enhance the implementation of IPECP. They allow us to activate a biopsychosocial, socioecological, person-centred, and evidence-based practice including ICF agreed shared language and ICF-informed clinical tools, assessments and evaluations that can support interprofessional education and team-based care. (Moran et al., 2020.)

In order to get the ICF implemented into the interprofessional practice, it is needed to agree number of actions. Jefferson (2017) states that the teams need to agree focus of introduction, identify which protocols of different disciplines are used in data collection and how that data is then documented. The process requires significant involvement from the team members and consensus about the aims.

ICF is based on an integration of medical and social models to provide a coherent view of different perspectives of health and disability from a biological, individual, and social perspective. In all contexts, consideration should be given to the complexity of combining information created in different settings by individuals with different levels of personal involvement or professional interests. Reliable knowledge upon which to take long term decisions should be based on a meaningful integration of all available information. (World Health Organization 2013, 45.)

Interprofessional competencies and ICF

ICF has been found to correspond the interprofessional learning outcomes and competencies. There are synergies listed below (Moran et al., 2020):

- Person / population centred
- Shared language / terminology - provides standardized ways of understanding and articulating persons functioning
- Shared collaborative goal setting
- Opportunities to explore own scope of practice
- Opportunities to explore shared scopes of practice
- Intersectoral collaboration
- Shared values
- Informed by evidence-based practice
- Focus on equality and social justice



Watch a video: How the ICF can enhance the person-centred and interprofessional collaboration – [a case example from South Africa from Dr Stefanus Snyman \(Youtube, 11:19 min\)](#)

2.3. How to gather person-centred information

How professionals can collect meaningful, person-centred data in a sufficiently comprehensive way is crucial for care or rehabilitation. Several methods have been developed to enable professionals to interview the person in the way that considers the person's needs. Here are some examples described. How to be person-centred professional We introduce here some ideas and approaches that can be seen to enhance person centredness.

Motivational and person-centred interview

Motivational interview is a person-centred interview the professional encourages to be self-directed. Motivational interviewing involves more listening than talking. It does not operate from a deficiency model that looks for ins lling knowledge, insight, skills, correct thinking, or even motivation. Even though the motivational discussion / interview is focusing on increasing motivation for change, and consolidating commitment (Hettema et al., 2005), the idea of it can be used as a basis of person-centred interview too.

These key principles of mo va onal interviewing (Rollnick & Miller 2009) support discussion with the person.

- empathy
- reflective listening
- asking open questions
- respecting the client's autonomy.

Asking personal questions

Asking personal questions like, incontinence, financial status, issues of neglect or abuse, mental health etc. could be sometimes challenging. Jefferson (2020) suggests a few advises for that.

Discussion tool

Otten with her colleagues is currently developing the digital conversation Discussion tool in Netherlands, which idea is to help the professional to start a conversation about factors which are relevant for a meaningful rehabilitation process. The discussion tool (Otten 2022) was developed during the ICF-Tools and practices task of the INPRO project. It helps the professional to clarify which are the most important things to the person e.g., values, relationships, motivations, important places etc.



Discussion tool (Otten 2022).



2.4. Ethical guidelines for ICF usage

It is essential that the use of the ICF respect the rights of everyone, including people with disabilities. ICF provides ethical guidelines for the use of the ICF. These are in line with the principles of the UN Convention and require involvement of the person concerned in the design of research and data systems.

Health professional students should develop, and professionals remember respect for the autonomy and dignity of their patients. ICF has eleven ethical provisions, on respect and confidentiality, clinical use of ICF and social use of ICF information (World Health Organization, 2001, 244–245.) It is stated that by following the ethical guidelines of the ICF the student will be guided towards a client-oriented approach respectful of cultural diversities. (World Health Organization, 2013, 53).

The person-centred approach to assessment and management can ensure that the contextual background of each person is considered during interactions and when assisting in the management of health and functioning. Students were found to identify and take greater ownership in addressing ethical challenges related to the case when applying ICF. (World Health Organization, 2013, 53.)

Ethical guidelines (World Health Organization, 2001:244–245)

Use of ICF Respect and confidentiality

- 1) ICF should always be used so as to respect the inherent value and autonomy of individual persons.
- 2) ICF should never be used to label people or otherwise identify them solely in terms of one or more disability categories.
- 3) In clinical settings, ICF should always be used with the full knowledge, cooperation, and consent of the persons whose levels of functioning are being classified. If limitations of an individual's cognitive capacity preclude this involvement, the individual's advocate should be an active participant.
- 4) The information coded using ICF should be viewed as personal information and subject to recognized rules of confidentiality appropriate for the manner in which the data will be used

Clinical use of ICF

- 5) Wherever possible, the clinician should explain to the individual or the individual's advocate the purpose of the use of ICF and invite questions about the appropriateness of using it to classify the person's levels of functioning.
- 6) Wherever possible, the person whose level of functioning is being classified (or the person's advocate) should have the opportunity to participate, and in particular to challenge or affirm the appropriateness of the category being used and the assessment assigned.
- 7) Because the deficit being classified is a result of both a person's health condition and the physical and social context in which the person lives, ICF should be used holistically.

Social use of ICF information

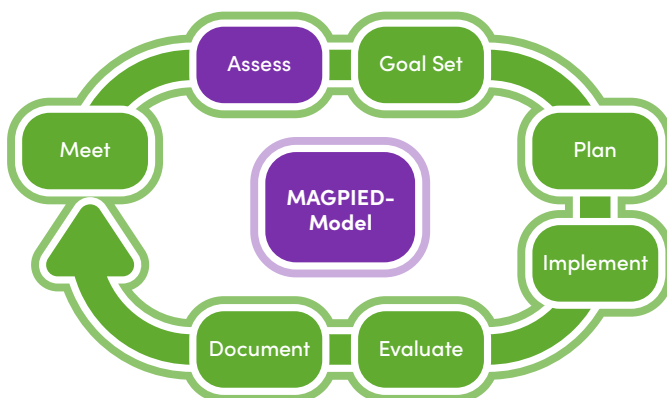
- 8) ICF information should be used, to the greatest extent feasible, with the collaboration of individuals to enhance their choices and their control over their lives.
- 9) ICF information should be used towards the development of social policy and political change that seeks to enhance and support the participation of individuals.
- 10) ICF, and all information derived from its use, should not be employed to deny established rights or otherwise restrict legitimate entitlements to benefits for individuals or groups.
- 11) Individuals classed together under ICF may still differ in many ways. Laws and regulations that refer to ICF classifications should not assume more homogeneity than intended and should ensure that those whose levels of functioning are being classified are considered as individuals. (ICF practical manual, draft 2013, WHO 2001; 244-245.)



2.5. Examples of Assignments

1. You meet a person for the first time – describe your role and responsibility as a representative of your profession.
2. Ethics and attitudes are important. Think, what are your values and have you any preconceptions
3. What effective communication within an interprofessional team means to you How ICF can facilitate that
4. What it means to be person-centred, when you use ICF

3. Assess



Learning objectives.

- To understand the use the ICF as a comprehensive framework for functioning assessment
- To recognize the different phases of assessment of functioning
- To be able to choose appropriate ICF tools for specific cases.

3.1. Disability

Disability is a complex process and is not a single, static stage (Madans et al., 2011). Functioning and Disability (ICF) and Health-Related Quality of Life represent two different perspectives from which to look at functioning and health, it is expected that both will often be used concurrently in clinical practice, research and health reporting (Cieza & Stucky, 2005b). WHO definition of a Quality of Life is that it is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (World Health Organization, 2023b).

Through the ICF lens, disability is considered not as a series of deficits within the person, but as an examination of the relationship between a person and their environment (Johannesen, 2019, 120). The ICF makes it possible for information about disability, and the processes by which impairments become activity limitations and participation restrictions. The measurement of disability must arise from a determination of the range of functioning, across all domains. (Leonardi, 2010.)

3.2. Assessment of person-centred functioning using the ICF

ICF offers a comprehensive frame for describing the different aspects of the person's life, functioning and disability. It provides an overview of functioning from the perspective of both the person and the interprofessional team. (Rauch et al. 2008, Wade, 2005.) The ICF support person centredness, focus on equality, social justice and evidence-based practices. It offers shared language and practical tools for assessment / evaluation, which support the teamwork. (Moran et al 2020.)

To illustrate the use of the ICF in rehabilitation practice, Swiss Paraplegic Research together with Swiss Paraplegic Centre (SPC), conducted a series of 20 **ICF-based case studies** following the rehabilitation cycle from 2007-2009 (ICF Research Branch, 2024).

Person centred information can be gathered in different ways. The person identified limitations or restrictions using own words can be gathered by self-assessment questionnaires, e.g., patient reported outcome measures (PROMs) or from the interview that is guided by the ICF components. The ICF provides a framework for describing a person's functioning, and it answers what different professionals should assess through observations and standardised assessment methods, but not how to do it. (Figure 4).

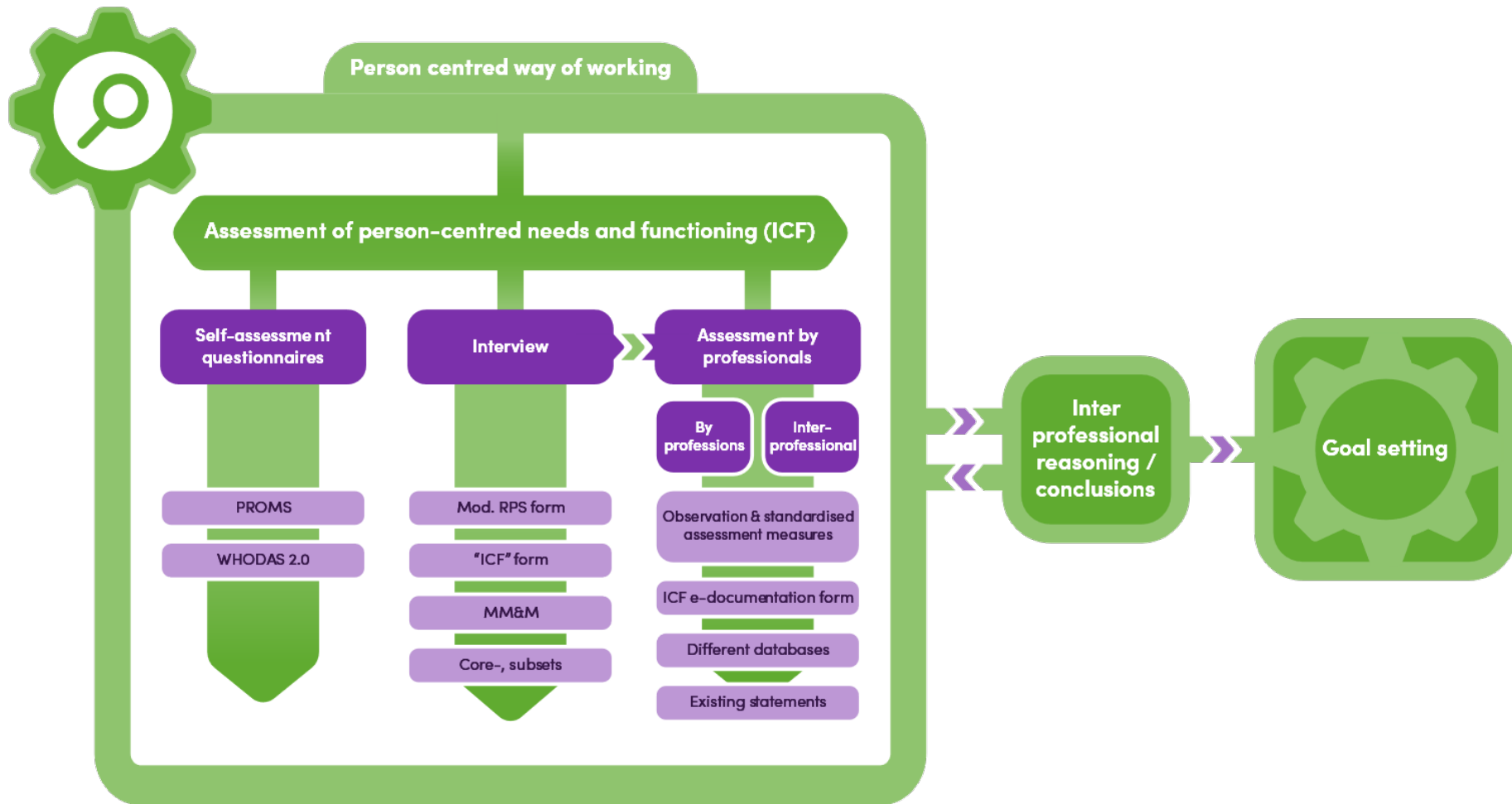


Figure 4. Assessment of person-centred needs and functioning (ICF).

3.2.1. Self-assessment questionnaires

Patient report outcome measures (PROMs)

Patient report outcome (PRO) is a term used to refer to any aspect of a personal report on an individual's health that comes directly from that person. These reports reflect the person's life experiences and values, without any interpretation of the person's responses by the healthcare professional or others. (FDA, 2009; ; Ronen, 2019,41.)

PROMs are standardised and validated person reported outcome measures. At the conceptual level the ICF and PROMs complement and enhance each other. Several generic PROMS as well as condition-specific PROMS have been developed. Some of them were developed before the ICF and therefore lack a reference to its framework. (Ronen, 2019, 45.)

The WHO has outlined that PROMS of functioning should cover a mix of body functions, activities and participation, environmental, and personal factors to represent a balanced biopsychosocial perspective (Ronen, 2019, 46). PROMs can include patient diaries, visual analogue and numeric rating scales (e.g., measures of pain severity), symptom measures, as well as multi-item, multidomain questionnaires (FDA, 2022). Professionals should familiarise themselves with existing PROMs that are relevant to their use (Kyte et al, 2014). They are not listed here.

The World Health Organization Disability Assessment Schedule (WHODAS 2.0)

The World Health Organization Disability Assessment Schedule (WHODAS 2.0) is a generic assessment instrument developed by WHO to provide a standardised method for measuring health and disability across cultures. It is grounded in the conceptual framework of International Classification of Functioning, Disability and Health (ICF). It integrates an individual's level of functioning in major life domains and directly corresponds with ICF's activity and participation dimensions. (World Health Organization, 2023c.)



covers six Domains of Functioning, including:

- Cognition – understanding & communicating
- Mobility– moving & getting around
- Self-care– hygiene, dressing, eating & staying alone
- Getting along– interacting with other people
- Life activities– domestic responsibilities, leisure, work & school
- Participation– joining in community activities

WHODAS 2.0 is available in several languages and there is a manual with detailed instructions (Üstün et al., 2010). It is applicable across cultures, in all adult populations as well as in both clinical and general population settings (World Health Organization, 2023c).

Depending on the information needed and the time constraints, the user may choose between multiple versions with different options for administration.

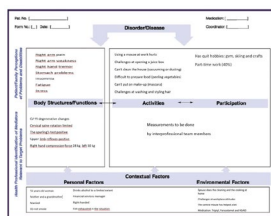
- 36-item version provides most detail and allows to compute overall and 6 domain-specific functioning scores.
- 12-item version is useful for brief assessments of overall functioning in surveys, allows to compute overall functioning scores and explains 81 % of the variance of the 36-item version.
- Both of them are available as interviewer-, self-, and proxy-administered forms.

3.2.2. ICF tools for interview

The ICF has great potential for enhancing clinical practice by providing a standardised description of functioning by means of ICF-based tools (Stücki 2012, vii). WHO (ICF Research Branch, 2017) as well as authors for example from University of Sydney (Madden et al., 2015) and Rural District Health Services (Kraus de Camargo et al., 2019, appendix 4) have created a series of tools based on the ICF. Some ICF based tools can be used to assess a person’s functioning at the interview phase.

Rehabilitation Problem Solving (RPS) Form / modified RPS form

The Rehabilitation Problem Solving (RPS) form visualizes the current understanding of the person’s (client’s /patient’s) state of functioning and disability, his/her target problems, and how the interprofessional team relates them to hypothetical mediators and contextual factors (Steiner et al., 2002; ICF Research Branch, 2018). It is also called as **ICF Assessment Sheet** (ICF Research Branch, 2018).



A filled RPS form as an example. [\(Click the preview icon to see full document\)](#)

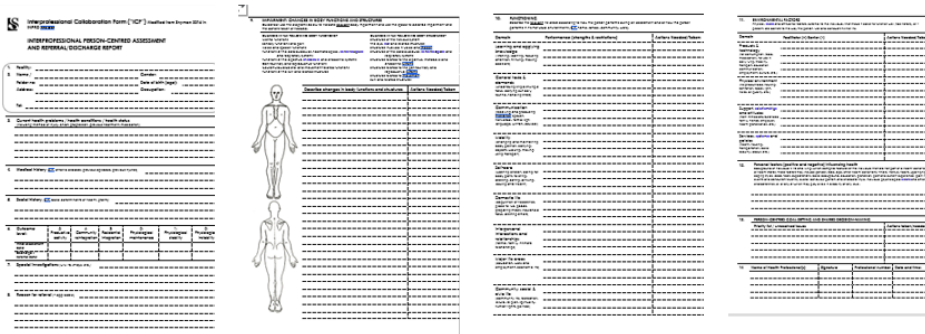
The RPS Form includes space for the person’s perspective, such as their symptoms and experiences, as well as the practitioners’ evaluation, including assessment findings and ICF classifications (Moran et al., 2020). Simon and Kraus de Camargo (2019, 72) described how to create an RPS form that also includes strengths of each component. The strengths and facilitators have been added to the INPRO modified RPS form in order to make the positive perspective of the person more concrete.



A blank RPS form modified by INPRO. [\(Click the preview icon to see full document\)](#)

Interprofessional Collaboration Form (ICF-form)

Interprofessional person-centred assessment and referral / discharge report, i.e., 'ICF' form, has been developed in Rural District Health Services (Western Cape, South Africa) and published by Kraus de Camargo et al. (2019, appendix 4. p.162–166).



An Interprofessional Collaboration form (with permission by Stefanus Snyman).

(Click the preview icon to see full document)

Monitoring Manual & Menu (MM&M)

Examples of the use of the ICF in the community are described by Madden et al. (2015, from page 10). Options for recording the Activities and Participation are:

- Difficulty in activity
- Need for assistance for activity
- Participation restriction
- Satisfaction with participation

ICF Core sets

The International Classification of Functioning, Disability and Health (ICF) offers an universally accepted framework to describe functioning, disability and health in persons with all kinds of diseases or conditions. The ICF is comprehensive and thus quite complex for use in daily practice where professionals need only a few of the categories found in the ICF. (ICF Research Branch, 2017.)

Through the rigorous scientific process several **Comprehensive and Brief ICF Core Sets** was developed for describing person's functioning profile. To complement the health condition specific ICF Core Sets the other ICF Core Sets have developed, e.g., ICF Generic set, Rehabilitation Set and minimal Set of Environmental Factors. ICF Core sets can be used to describe person's functioning in detail. (ICF Research Branch, 2017.) They can form the basis for an interview with the client or a pre-information form.

All the Core sets can be found in the interactive electronic **ICF-based Documentation Form** (ICF Research Branch. 2023).

There are ICF core sets for:

- Neurological conditions
- Cardiovascular and respiratory conditions
- Cancer
- Mental Health
- Musculoskeletal conditions
- Diverse situations
- Other health conditions

Code-/Subsets

Code set or Subset is called, when the organisation creates their own collection of ICF categories for the specific purpose. The development of the ICF-subset (preliminary core set) should be based on the same process as the core set: 1. systematic research, 2. patients', 3. experts' and 4. the clinical perspectives. (ICF Research Branch, 2017.)



Example: a subset for community-dwelling older adults

In the development process of the community-dwelling older adults' subset the most relevant categories were identified. This subset includes categories from activities and participation only and therefore it gives information that adds value or new perspective in the primary care consultations. Categories related to body functions and structures were excluded, because those are already routinely documented and would therefore only duplicate information. Categories related to activities and participation are not as obvious and are therefore of particular importance when caring for older people. (Rink et al., 2023.)

This subset includes 51 second-level ICF to describe the functioning of community-dwelling older adults: learning and applying the knowledge (8), general tasks and demands (2), communication (5), mobility (13), self-care (7), domestic life (6), Interpersonal interactions prioritised the patients' perspective as the most important and voted to focus on the ICF component of activities and participation to provide a more holistic perspective in primary care. These categories will be used to develop an ICF-based questionnaire for community-dwelling older adults. (Rink et al 2023.)

3.2.3. Assessment by any professionals

ICF functioning profile

ICF qualifiers can be used to record the level of limitations, restrictions, barriers, or facilitators. Using the qualifiers 0-4 or 8, the professional can describe the person's functioning profile by ICF-based documentation form. It is a free access tool based on ICF core sets for professionals to create the functioning profile (ICF Research Branch, 2018). The professional can choose any ICF Core Set and supplement the chosen Core Set, if needed with any ICF category too. As a result, the professional can get a visual output of Functioning profile for chosen categories. Note, that person factors (pf) are not included in the ICF functioning profile. You can learn more about ICF qualifiers in INPRO ICF Basic course.

An example of an ICF Categorial profile can also be found in the ICF Research Branch (2018) Case studies.

Example of the e-documentation form (ICF Research Branch 2023).

(Click the preview icon to see full document)

Standardised assessment methods by professions

Relevant ICF categories need to be assessed by interprofessional team members using existing valid and reliable measures (see examples below). The ICF is hardly mentioned in the names of the measures. New ICF-based measures have been developed, and the content of existing ones have been linked to the ICF. (Rauch et al., 2008.)

It is important to choose the most relevant areas to assess, identify the person's concerns and the support needed and describe or compare functioning (over time). Deciding how and what to record also entails deciding when to record. All components of disability (impairments, activity limitations, participation restrictions) should be considered, as well as the environmental and personal factors that affect them. The interactions among all components are of key interest. All domains (chapters) of Activities and Participation are required to describe functioning in diverse populations. A subset of these domains cannot predict the whole picture of activities and participation. (Madden et al., 2013.)



examples of outcome measures can be found in the following databases

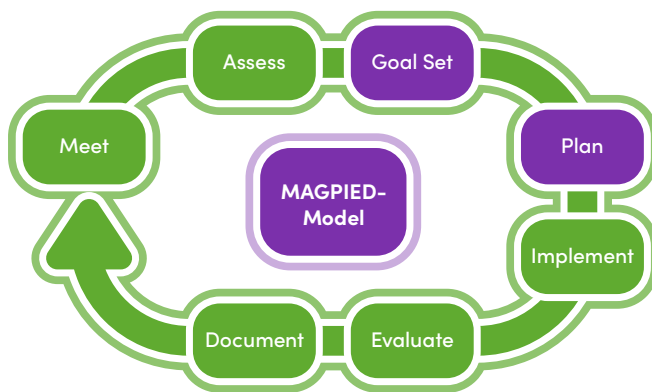
Database	Link	Language/setting
Rehabilitation Measures Database	Rehabilitation Measures (sralab.org)	English/generic
Outcome measures – Physiopedia	Outcome Measures – Physiopedia (physio-pedia.com)	English/physiotherapy
Assessments and Outcome Measures – RCOT	Assessments and Outcome Measures – RCOT	English/occupational therapy
RCSLT outcome measurement	https://www.rcslt.org/speech-and-language-therapy/guidance-for-delivering-slt-services/outcome-measurement/	English/speech and language therapy
The Functioning Measure Database, TOIMIA	TOIMIA-tietokanta – Duodecim (terveysportti.fi)	Finnish/generic
Formulärsammanställning	https://www.fbanken.se/	Swedish/generic

3.3. Examples of Assignments



1. How is assessment of functioning combined with ICF
2. Try at least one ICF-based form for interviewing the person or client
3. Look at one ICF Core Set that interests you and think about how you could assess functioning within different ICF categories.
4. Watch the [videos about the patient Maria and different professionals talking about Maria's functioning](#). Describe the person's functioning using the modified RPS form or 'ICF' form.
5. Discuss what is the difference between functioning and quality of life
6. Watch the video [the professional interviewing the patient \(Youtube\)](#). Write down the information to the modified RPS form or 'ICF' form.

4. Goal-set and plan



Learning objectives.

- To recognise the role of ICF in goal setting
- The principles of person-centred interprofessional goal setting process
- To learn to use the ICF based goal setting tools

4.1. Analyse, identify and integrate

Person-centred goal setting in an interprofessional team is an essential part of rehabilitation process. The goals need to set for the immediate future and also for the longer term. In rehabilitation, there will be more emphasis upon establishing the person's needs and wishes, and more emphasis upon longer term goals, usually at the level of activities or participation. (Stucki & Grimby, 2007; Wade 2005.) ICF can help identify and describe problems in functioning which can support the identification of treatment needs and desired outcomes. WHO Practical Manual of using the International Classification of Functioning, Disability and Health (ICF) states, that well planned implementation of ICF data collection in clinical or other applied settings will maximise the benefit to be obtained from such data (World Health Organization, 2013). Motivational interview can be used for goal-setting method that helps to strengthen the client's own motivation and commitment to a specific goal (Hetteema et al., 2005). It is centrally defined not by technique but by its spirit as a facilitative style for interpersonal relationship (Rollnick & Miller 2009).

How to find a good goal

ICF can help identify and describe person's problems in functioning which can support the identification of treatment needs and desired outcomes. Well planned implementation of ICF data collection in clinical or other applied settings will maximise the benefit to be obtained from such data. The different components of the ICF can be seen as a core of goal setting at different stages of treatment or rehabilitation (Figure 5). The person / client involvement is essential for goal setting, i.e., person centredness. The main objective in goal setting should be set to the participation level, what the person should be able to do in his life. Setting goals also depends on the rehabilitation process (Figure 6). (Rauch et al 2008.)

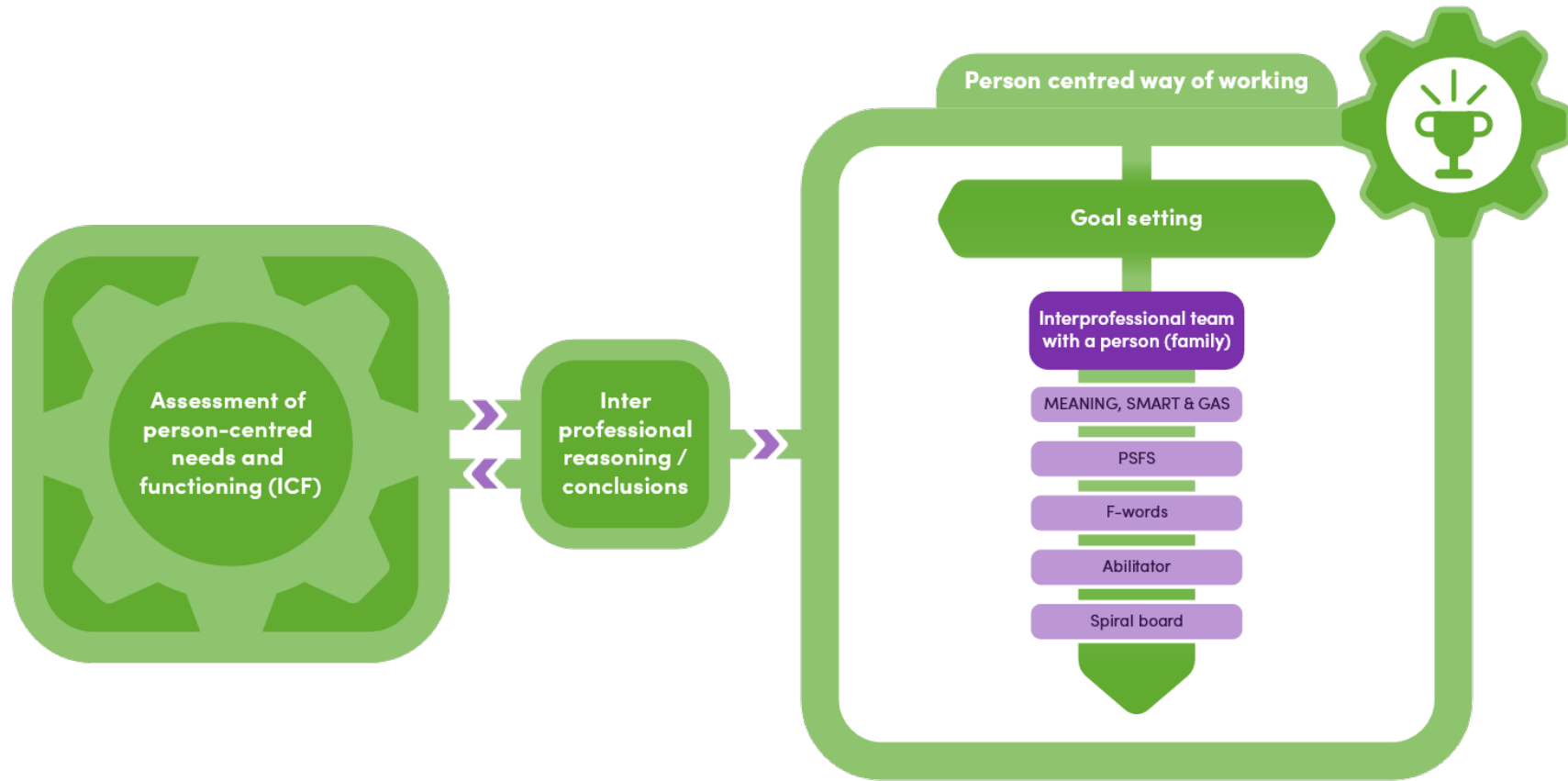


Figure 5. Interprofessional reasoning and goal setting.

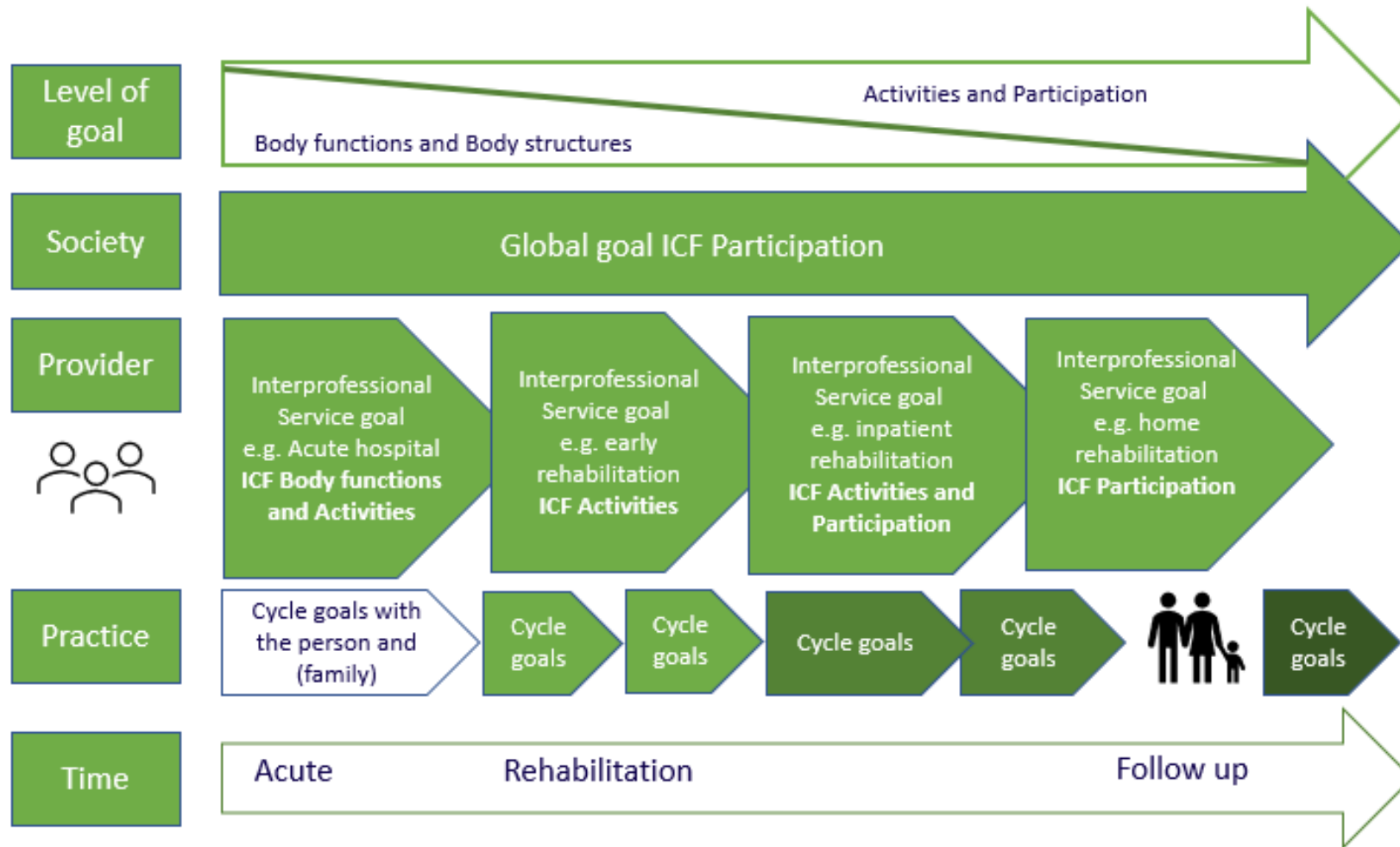


Figure 6. Rehabilitation process and goal setting (Modified from Rauch et al. 2008, 355)

4.2. Principles for goal setting

Shared Decision Making

The process of discussion and negotiation is the key element in person-centred, interprofessional goal setting. However, the equal shared decision making is challenging both for clients and professionals. ICF can enhance the collaboration in rehabilitation. The advantage of the ICF is that it acknowledges the person's experiences, the impact of disease(s) on their lives and it considers the environmental and personal factors too. The goal-oriented program should focus on participation level but should also take into account the person's impairments. (Playford 2015.)

MEANING

MEANING principle is defined by McPherson et al. (2015). They refer about person's experiences of meaningful life, which reminds professionals to think about actions and activities during the goal setting process. MEANING acronym consists of seven activities:

- (M) Meaning: Meaningful overall goals identified.
- (E) Engage: Engage to establish trust and communication to discuss what is meaningful
- (A) Anchor: Anchor / verbalise sub-goals for client as a tool for making sense of therapy
- (N) Negotiate: Negotiate levels of progress towards attainment (eg. GAS)
- (I) Intention-implementation gap: Specific steps are needed to bridge the intention-implementation gap
- (N) New goals: View the goal setting as part of the therapeutic process versus simply a means to an end
- (G) Goals as behaviour change: Recognize the goals as an active intervention that impacts on people's actions, mood or motivation.

SMART

The SMART principles are used e. g. , when setting the goals with GAS (Turner-Stokes, 2009). It is well known acronym in goal setting on several occasions, especially in rehabilitation (McPherson et al., 2015).

The SMART acronym is most interpreted as (Wade 2009):

- (S) Specific (M) Measurable (A) Attainable (R) Relevant (T) Timely

Goal Attainment Scaling (GAS)

The GAS is proposed as a person-centred rating scale, which focuses on the person’s own priorities. The goal setting process provides discussion with the person and his family. Its advantage is that the GAS goal supports the communication and collaboration of an interprofessional team. The GAS rating scale will be defined from -2 to 2, where the 0 is an expected outcome. GAS goals can be linked to the ICF fluently. (Turner-Stokes 2009.)

Table 2. Example of the GAS goals (Asford & Turner-Stokes 2015, 126).

GAS GOALS	Hand and arm use d445	Walking d450
-2 (At baseline)	Unable to use hand at all	Unable to take any steps even with maximal assistance from two people
-1 (Partially achieved)	Requires help to get hand around cup, unable to hold cup upright	Takes 1-2 steps with assistance
0 (As expected)	Uses hand to grasp and stabilize cup while pouring a drink	Walks short distances indoors with walking aid and standby supervision
+1 (A little more)	Uses hand to lift cup to mouth and drink	Independently walking indoors with or without a walking aid
+2 (A lot more)	Uses hand normally	Walks independently indoors and outdoors, with or without a walking aid
Result		

4.3. ICF Tools for goal setting

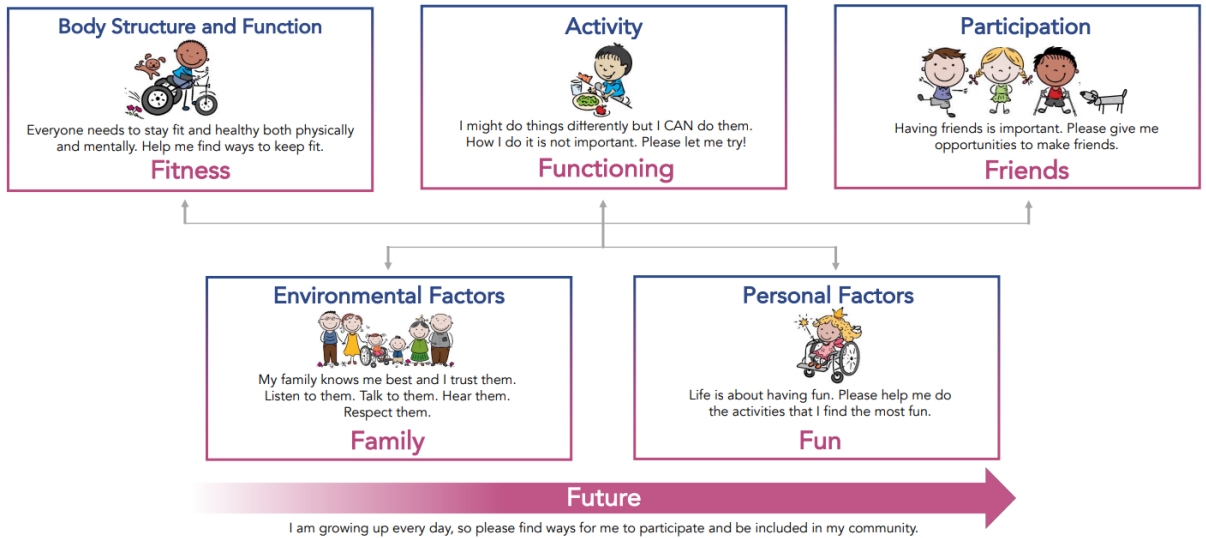
F-words

F-words for children and families is developed by Rosenbaum and Gorter (2012) based on the ICF. The 'F-words for Child Development' consists of six words: Functioning, Family, Fitness, Fun, Friends, Future (Figure 7), providing a family-centred, strengths-based, holistic approach to set goals for child health and development. F-words can be applied for adults too. Related materials can be found on [the CanChild website](#).



ICF Framework and F-Words for children poster (CanChild)

The ICF Framework¹ and the F-Words²



For more information visit the F-words Knowledge Hub:
www.canchild.ca/f-words



1) World Health Organization. (2001) *International Classification of Functioning, Disability and Health (ICF)*
2) Rosenbaum P & Gortals JW. (2012). The F-words in childhood disability: I swear this is how we should think! *Child Care Health Dev*; 38.



There are several F-words tools available in many languages on the CanChild website.

- F-words Agreement Template [F-Words Agreement Template \(canchild.ca\)](http://canchild.ca)
- F-words Collage [F-Words Collage \(canchild.ca\)](http://canchild.ca)

- F-words Profile [F-Words Profile \(canchild.ca\)](http://canchild.ca)

- F-words Goal sheet [F-Words Goal Sheet \(canchild.ca\)](https://www.canchild.ca)

Patient Specific Functional Scale (PSFS)

Stratford et al. (1995) originally developed a Patient-Specific Functional Scale for physiotherapists working with orthopedic patients. It has been found to be useful in many situations where the challenges of daily living are asked, not just for physiotherapists. If qualifiers are used, the assessment scale must be reversed.

The Patient-Specific Functional Scale

This metric questionnaire was developed to quantify activity limitations and determine functional response for patients with an orthopedic condition.

Instructions to read and fill in below: Complete at the end of the history and prior to physical examination.

Initial Assessment:

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your _____ problem(s). Please use three separate lines that you are unable to do or having difficulty with because of your _____ problem(s). (Instructions: Start with the greatest and last with the least.)

Follow-up Assessments:

When I re-evaluated you on (state previous assessment date), you told me that you had difficulty with (read all activities listed but not a last). Today, do you still have difficulty with (read and have patient cover each item on the list)?

Patient-specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

0: Unable to perform activity
10: Able to perform activity at the level you wish to attain after surgery or problem

(Date and Score)

Activity	Initial									
1.										
2.										
3.										
4.										
5.										
Additional										
Additional										

Total score = sum of the activity scores (range of activity scores = 0-30 points)
Maximum desirable change (MDC) for average score = 7 points
Minimum desirable change (MDC) for single activity score = 3 points
PSFS developed by (Stratford, P., Gill, C., Weir, M., & Bunker, J. (1995). Assessing disability and change on individual patients: report of a patient-specific measure. *Chiropractic Journal*, 42, 214-220).
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Patient-Specific Functional Scale

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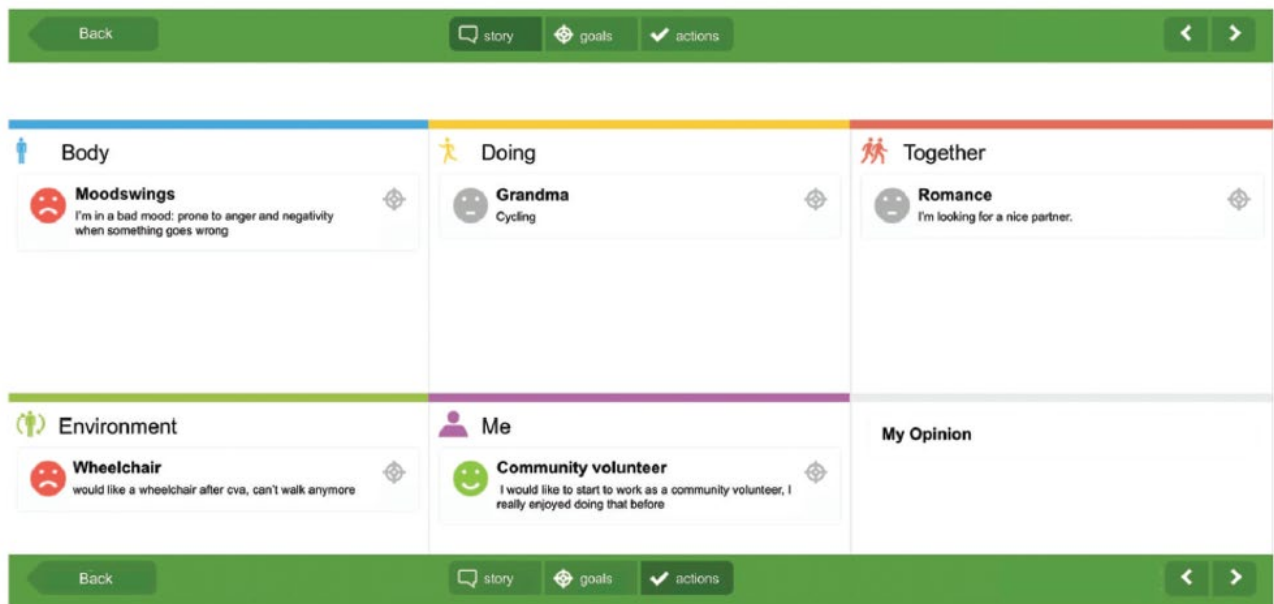
ICF e-health application

The e-health application is developed in Netherlands 2011 by a Dutch IT company, ICF experts, health professionals, and end-users collaboratively (van der Veen et al., 2023). By using the e-health application a person him/herself can record both individual assessment of functioning and set personal goals.

The assessment can address all aspects of functioning, perceived as positive, neutral or negative. In addition, the application provides the opportunity to record individual goals and related actions. Goals regarding functioning are chosen by the user.



E-Health application (van der Veen et al., 2023, 2387)



Spiral-board game

Spiral-board game was developed by Finnish rehabilitation counsellor Kirsi Niittymäki in order to increase the person-centredness in rehabilitation goal setting among psychiatric patients. This practical tool is available for health care professionals working with either psychiatric adult clients or young neuropsychiatric clients. (Rehabilitation Foundation, 2018.)

- Spiral for persons undergoing mental health rehabilitation
- Spiral for young persons with autism spectrum disorders
- Spiral for adults with language related difficulties (aphasia)
- Spiral for children with language related difficulties
- Spiral for families with language related difficulties

Rules, game board and berry markers are the same for each target group. Each target group has own questions on cards and reply-forms. Materials can be printed in colours on strong paper. The e-version game is available in Finnish too.

During the game each participant reads a question card aloud, 24 together, and then decides if the area is problematic for him/her or not. The answers are written down to a personal assessment form according to a scale from 'no problems at all - to severe problems' or answered digitally. The rehabilitation goals are formulated based on the answers given by the participant during the game.

Spiral-board game consists of a game board and 24 question cards based on ICF categories (Rehabilitation Foundation, 2018).



The Spiral-board Game




Example: A question card and corresponding ICF codes for persons undergoing mental health rehabilitation

Questions and ICF

SPIRAL-questions for persons undergoing mental health rehabilitation	ICF-code	ICF- classification of health-related domains
1. Daily routines • How well are you able to carry out daily routines? <i>For instance cooking food, washing oneself.</i>	d230	Carrying out daily routine
2. Ability to relax • Do you have ways of relaxing that work for you?	d240	Handling stress and other psychological demands
3. Conversation between two persons • Are you able to start and sustain conversations with a friend?	d3503	Conversing with one person
4. Conversation in a group • Is it easy for you to converse in a group? <i>For instance expressing your own opinion, speaking when it is your turn, listening to others.</i>	d3504	Conversing with many people
5. Moving around in different locations • Do you have difficulties in moving around outside your home on your own? <i>For instance unfamiliar places, new routes, open spaces.</i>	d460	Moving around in different locations
6. Physical exercise • Do you care for your health by exercising regularly?	d598	Self-care, other specified
7. Eating • Do you eat regularly? • Do you eat varied meals?	d550	Eating
8. Social flexibility • Is it easy for you to make friends? • Are you quick to quarrel with others?	d720	Complex interpersonal interactions

Reply form

Example: Spiral-board game reply form

 Assess whether you have difficulties with the topics mentioned in the question card and write a dash in the appropriate point on each scale. Also indicate, by ticking the appropriate section, whether you want to achieve personal change on the topic in question.

Date: _____

Name:	As regards this topic I ...		I want a change to this
	☹️ ... have a lot of difficulties	☺️ ... do not have any difficulties at all	yes no
1. Daily routines	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
2. Ability to relax	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
3. Conversation between two persons	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
4. Conversation in a group	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
5. Moving around in different environments	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
6. Exercise	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
7. Eating	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
8. Social flexibility	_____	_____	<input type="checkbox"/> <input type="checkbox"/>

Abilitator

The Abilitator is a self-report questionnaire that any working-age person can use to assess their own work ability and functioning (Wikström et al., 2023). The Abilitator is available in Finnish, Easy Finnish, Swedish, Arabic, English, Farsi, Dutch, Japanese, Somali and Kurdish (Sorani). Using the Abilitator questionnaire does not require any specific professional or educational background, making it an effective shared tool for multidisciplinary and cross-sectoral networks. The Abilitator is not a diagnostic method. The Abilitator is linked to the ICF. More information on [The Finnish Institute of Occupational health](#).

When completed via the Abilitator online service, it provides the respondent with feedback that is designed to be easy to understand, encouraging and safe to receive. The feedback provides the respondent with personal insight and can help them reflect on their current situation from the perspective of their strengths and challenges related to work ability and functioning.

Information from The Abilitator can be used for (Wikström et al., 2023):

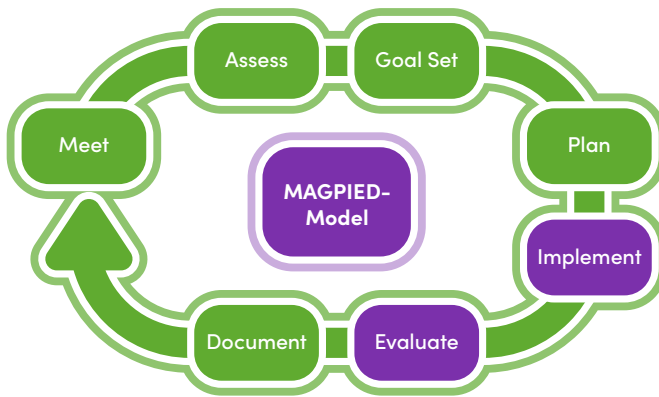
- assessment of work ability and service needs,
- setting goals,
- planning the actions,
- evaluation of changes.

4.4. Examples of Assignments



1. How ICF can be used in goal setting phase
2. Discuss what is needed for successful joint decision-making
3. Choose two ICF based tools for goal setting and compare tools. What are advantages and do you find any disadvantages
4. Look at Spiral-board game question card and corresponding ICF codes.
5. [Try Abilitator](#)

5. Implement and evaluate



Learning objectives:

- To learn to use the ICF forms for planning the interventions
- To learn to use the ICF functioning profile as an evaluation tool

Once the intervention has been implemented, the next phase in the rehabilitation process is to evaluate the effects of the interventions against the goals set. In the end of rehabilitation an evaluation is needed to see, if there have been any changes in functioning. The interprofessional team needs to determine whether there are still unresolved but resolvable problems, in which case the cycle continues, or all goals have been achieved. The same components of ICF and the same evaluation methods, e.g., measures, should be utilized than in the beginning of the rehabilitation process. (Rauch et al. 2008; Wade 2005.) The **ICF-based case studies** illustrate also the use of the ICF in intervention and evaluation phases (ICF Research Branch, 2024).

5.1. Rehabilitation implementation

ICF Intervention table

Using the ICF Intervention table, the interprofessional team with the person can set person-centred goals. The ICF-based tool provides a comprehensive overview of the 'person's intervention goals, the intervention itself, and the corresponding rehabilitation team members assigned to address each intervention goal. It should be noted that rehabilitation interventions often address two (or more) ICF domains. An ICF intervention table can be used to describe the levels of functioning at baseline, target, and final assessment scores. The values are described using ICF qualifiers. (ICF Research Branch, 2018.)

Figure 4: Intervention Table
Phys: Physician, PT: Physiotherapist, Sp: Sport therapist, Psych: Psychologist, SW: Social worker, Arch: Architect (Spinal Cord Injury, ASIA A Th 3, 12 weeks after trauma).

Intervention target	Intervention	Phys	Nurse	PT/Sp	OT	Psych	SW	Arch	Final value	Goal value	End value	
Body functions/structures	028013 Pain in the back			X								
	0415 Blood vessel functions at risk		X						3	0	1	
	0420 Blood pressure function		X						0	0	0	
	07101 Mobility of several joints		X						1	0	0	
	0750 Involuntary movement functions			X					1	0	1	
	0760 Supportive functions of the same			X					2	0	0	
	0780 Sensation of muscle stiffness			X					1	0	0	
	0810 Structure of the skin - at risk	Daily inspection		X					0	0	0	
	Activities and Participation	0410 Changing basic body position			X					1	0	0
		04103 Maintaining a sitting position	Body balance training		X					1	0	0
04200 Transferring oneself while sitting		Transfer training		X					2	1	1	
04201 Moving around with wheelchair		Wheelchair training outdoor		X					3	1	1	
04202 Washing oneself		Assistance/instruction		X					2	0	0	
04203 Caring for body parts		Assistance/instruction		X					2	0	1	
05300 Regulating urination		Assistance/instruction		X					2	0	0	
05301 Regulating defecation		Assistance/instruction		X					2	0	0	
0540 Dressing		Assistance/instruction		X					2	0	0	
05501 Sport		Exercising different sports		X					4	2	2	
IPF	01107 Assistive products: Chair cushion			X					-2	0	0	
	01101 Assistive products for personal mobility: Wheelchair and adapted car	Testing of different wheelchairs, reconstruction of car and adapted car		X					-3	-2	-2	
	01101 Design, construction and building products and technology of buildings for private use: Home	Planning and reconstruction of private building		X					-3	-2	-2	
	05700 Social security services	Clarification, Organization of payments					X		0	4+	2+	
	Knowledge	Teaching, consulting and lectures	X	X	X	X	X		2	2+	2+	
IP	Acceptance/Coping of disease		X	X	X	X		1	0	1+		

ICF Case studies: Intervention table (ICF Research Branch, 2018)

5.2. ICF tools for evaluation

Evaluation Display

The ICF Evaluation Display is based on the ICF Categorical Profile made by ICF-based documentation form. The ICF Evaluation Display includes only the ICF categories that were defined as intervention targets i.e. those categories that were related to a specific goal (global goal, service-program goal and/or cycle goal). (ICF Research Branch, 2018.)

Assessment (12 weeks post-trauma)		Evaluation (18 weeks post-trauma)	
Global Goal: Complete independence	0	not evaluated yet	
Service-Program-Goal: Independence in ADLs	0	not evaluated yet	
Cycle goal 1: 05 Independence in mobility	1		+
Cycle goal 2: 05 Independence in self-care	0		+
Cycle goal 3: 0501 Sport	2		+
ICF categories - Intervention Targets	ICF Qualifier	Goal relation Value*	Goal achievement
	problems 0 1 2 3 4		problems 0 1 2 3 4
028013 Pain in back	1	0	-
0415 Blood vessel functions - at risk	G	0	+
0420 Blood pressure functions	1	0	+
07101 Mobility of several joints	1,2	0	-
0735 Muscle tone functions	1	1	+
0755 Involuntary movement reaction functions	1,2	0	+
0760 Supportive functions of the same	1,2	0	+
0780 Sensation of muscle stiffness (M. trapezius)	1,2	0	+
0810 Structure of areas of skin - at risk	G	0	+
0410 Changing basic body positions	1	0	+
04103 Maintaining a sitting position	1,2	1	+
04200 Transferring oneself while sitting	1	1	+
04201 Moving around using equipment	1	0	-
04202 Washing oneself	1	0	-
04203 Caring for body parts	2	0	-
05300 Regulating urination	2	0	+
05301 Regulating defecation	2	0	+
0540 Dressing	2	0	+
05501 Sport	3	2	+
	facilitator 4+ 3+ 2+ 1+ 0 1 2 3 4		facilitator 4+ 3+ 2+ 1+ 0 1 2 3 4
01101 Drugs		1,2	2+
01101 Assistive products: Chair cushion		1	0
01101 Assistive products: motorized wheelchair, car		1	0
01101 Design and construction of private building		SP	3
05700 Social security services		SPG	4+
05750 General social support services		SPG	3+
	positive influence neutral negative		positive influence neutral negative
IP Knowledge		SP	+
IP Acceptance of disease		G	0

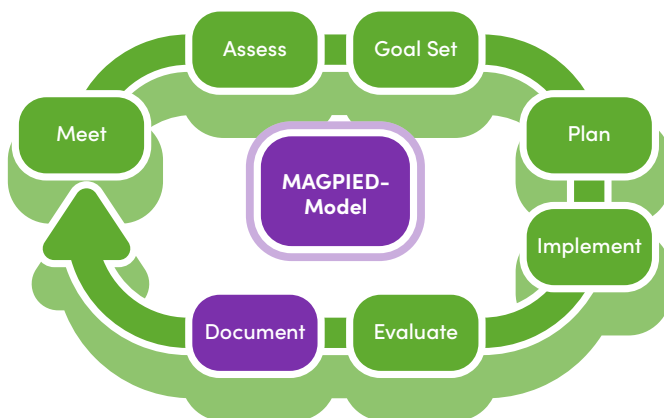
ICF Evaluation Display (ICF Research Branch, 2018)

5.3. Examples of Assignments



1. Watch the video [Moorheilbad Harbach – Team meeting in Rehabilitation](#) (Youtube, 11:46 min) and pick up the interprofessional goal and interventions mentioned in the video to [the ICF Intervention table](#) above.
2. Reflect the video – What was positive and what could have been done differently previous video example

6. Document



Learning objectives:

- Get to know how ICF can be used in documentation.



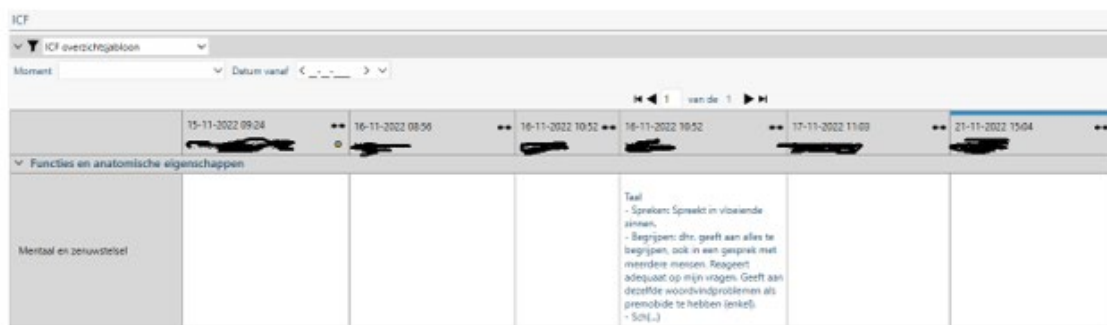
Documenting examples

There are variety of ways of documenting functioning data around the world. Here we describe a few examples from Netherlands, Austria and Finland.

Netherlands

ICF table in electronic patient device in Revalidatie Friesland.

Table:



ICF	
ICF overzichtsgabloon	
Moment	Datum vanaf
	15-11-2022 09:24
	16-11-2022 08:56
	16-11-2022 10:52
	16-11-2022 10:52
	17-11-2022 11:03
	21-11-2022 15:04
Functies en anatomische eigenschappen	
Mentaal en zenuwstelsel	Taal - Spreken: Spreekt in vloeiende zinnen. - Begrijpen: dnr. geeft aan alles te begrijpen, ook in een gesprek met meerdere mensen. Reageert adequaat op mijn vragen. Geeft aan dezelfde woordvindproblemen als gremobide te hebben (enkel). - SCHJ

Austria

The ICF is applied in documenta on in Moorheilbad Harbach. They have made a step-by-step guideline for dietitians.

Finland

According to the new specifications and recommendation by Finnish Institute for Health and Welfare, functioning data will only be recorded under the heading "Functioning" in a structured way. Structurally recorded information is transmitted in the same way to all professionals treating the client / patient. It can be applied to statistics and follow-up reports more easily than information recorded as free text.

When documenting functioning, the specific structure is recommended to use the titles (THL 2023):

- The environment where the assessment is done.
- Subject (functioning, environmental factor e.g., washing, eating, pain, home environment, family attitudes etc.). Use free text or ICF category.
- Assessment / evaluation tool / method (e.g., specific measurement, interview, observation etc.)
- Result (what is the result of evaluation; use number, text and/or picture)

It is recommended that ICF categories be used in the future when ICF is integrated into client and patient information systems.

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8. Glossary of terms

Term	Description
Activity	In the International Classification of Functioning, Disability, and Health, the execution of a task or action by an individual.
Activity limitations	In the International Classification of Functioning, Disability, and Health, the level of functioning an individual may have in executing activities.
Barriers	In the International Classification of Functioning, Disability, and Health, refer factors in a person's environment that, through their absence or presence, limit functioning and create disability.
Body functions	In the International Classification of Functioning, Disability, and Health, the physiological functions of body systems (including psychological functions).
Body structures	In the International Classification of Functioning, Disability, and Health, the anatomical parts of the body such as organs, limbs, and their components.
Capacity	In the International Classification of Functioning, Disability, and Health, construct that indicates, as a qualifier, the highest probable level of functioning that a person may reach in a domain in the Activities and Participation list at a given moment. Capacity is measured in a uniform or standard environment, and thus reflects the environmentally adjusted ability of the individual.
Categories	In the International Classification of Functioning, Disability, and Health, categories are classes and subclasses within a domain of a component, i.e. units of classification.
Disability	In the International Classification of Functioning, Disability, and Health, an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).
Environmental factors	In the International Classification of Functioning, Disability, and Health, refer to all aspects of the external or extrinsic world that form the context of an individual's life and, as such, have an impact on that person's functioning. It includes the physical, social, and attitudinal environment in which people live and conduct their lives.
Facilitators	In the International Classification of Functioning, Disability, and Health, refer factors in a person's environment that, through their absence or presence, improve functioning and reduce disability.
Functioning	In the International Classification of Functioning, Disability, and Health, an umbrella term for body functions, body structures, activities and participation. It denotes the positive aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).
GAS	Goal Attainment Scaling
ICF	International classification of functioning, disability and health

Impairments	The problems in body function or structure such as a significant deviation or loss as classified in the ICF.
Interprofessional collaboration	Interprofessional teams engage in a high level of collaborative care; team members from different professional disciplines work interdependently to develop a unified plan for person assessment and treatment. Interprofessional team members acquire knowledge about team developmental processes and share responsibility for both the effective functioning of the team and leadership functions.
MAGPIE	Rehabilitation process published by the Health Queensland. The MAGPIE acronym stands for the following clinical team functions: Meet, Assess, Goal-Set, Plan, Implement and Evaluate.
Participation	In the International Classification of Functioning, Disability, and Health, involvement in a life situation.
Participation restriction	In the International Classification of Functioning, Disability, and Health, problems an individual may experience in involvement in life situations. The presence of a participation restriction is determined by comparing an individual's participation to that which is expected of an individual without disability in that culture or society.
Performance	In the International Classification of Functioning, Disability, and Health, construct that describes, as a qualifier, what individuals do in their current environment, and so brings in the aspect of a person's involvement in life situations.
Personal factors	In the International Classification of Functioning, Disability, and Health, contextual factors that relate to the individual such as age, gender, social status, life experiences and so on, which are not currently classified in ICF, but which users may incorporate in their applications of the classification.
PROMS	Patient-reported outcome measures.
Qualifiers	In the International Classification of Functioning, Disability, and Health, denote, for example, the magnitude of the level of health or severity of the problem at issue. Qualifiers are coded as one, two or more numbers after a point.
SMART	Acronym form the words: specific, measurable, achievable, realistic/relevant and timed.
WHO	World Health Organization
WHODAS 2.0	WHO Disability Assessment Schedule 2.0.
WHO-FIC	WHO Family of International Classifications Network. The principal role of the WHO-FIC Network is to promote the implementation, use, maintenance, and updating of the WHO reference health classifications. WHO Family of International Classifications Network

Attachments

Pat. No. [_____]

Medication: [_____]

Form No.: [_] Date: [_____]

Coordinator: [_____]



Disorder/Disease

Vertical text on the left side of the central box: Patient/Family Perceptions of Problems and Disabilities

Right arm pain
Right arm weakness
Right hand tremor
Stomach problems
 Insomnia
Fatigue
Stress

Body Structures/Functions

CV-VI degenerative changes
Cervical spine rotation limited
The spurling's test positive
Upper limb reflexes positive
Right hand compression force 28 kg, left 30 kg

Using a mouse at work hurts
 Challenges at opening a juice box
 Can't clean the house (vacuuming or dusting)
 Difficult to prepare food (peeling vegetables)
 Can't put on make-up (mascara)
 Challenges at washing and styling hair

Has quit hobbies: gym, skiing and crafts
 Part-time work (40%)

Activities ↔ **Participation**

Measurements to be done
 by interprofessional team members

Vertical text on the left side of the bottom box: Health Professional Identification of Mediators Relevant to Target Problems

Personal Factors **Contextual Factors** **Environmental Factors**

55 years old woman	Drinks alcohol to a limited extent	Spouse does the cleaning and the cooking at home
Mother and a grandmother	Financial services manager	Challenges at workplace attitudes
Married	Right-handed	The central mouse has helped a bit
Do not smoke	Felt <u>exhausted in the situation</u>	Medication: Triptyl, Paracetamol and NSAID

Example from the RPS form published by Steiner et al. (2002)

Asking personal questions – a few examples

1) Setting the scene

Jefferson (2020)

- At the beginning of the assessment
- To prepare the client / patient in advance

For example:

“I am going to ask a lot of questions for us to fully understand your needs and how we can best help you. Some of these questions might be obvious, some might sound silly, and some might more private matters.”

“I do ask that I can share information that would help your rehabilitation, with other health professionals involved in your care e.g., physiotherapist, occupational therapist, social worker.”

2) The sensitivity sandwich.

- You can re-prepare your client or patient to questions e.g., “As I mentioned earlier, some of the questions I need to ask are more sensitive. If you do not want to answer them, just let me know. You do not have to if you do not want to...”
- The sandwich
 - Universal approach e.g., “Many people in your situation...”
 - Ask the questions with curiosity e.g., “I am wondering whether you might have experienced any difficulties in...” or “Do you feel you have difficulties with...?”
 - Reinforce the normal experience e.g., “That is quite common with your difficulties....” or “... as I mentioned that is quite normal (name the condition), such as” “Thank you for sharing this with me”

3) Nonverbal communication

- Eye contact
- Gestures, facial expressions
- Posture and body language
- Use of space and environment, like personal space
- Touching
- The rhythm and tone of speech

ICF-based Documentation Form

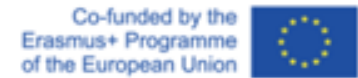
ICF Research Branch, 2018

Reminder: The categories of the Generic Set are indicated by the letter (G).

PATIENT INFORMATION							
/							
BODY FUNCTIONS							
Physiological functions of body systems (including psychological functions)							
<i>How much impairment does the person have in ...</i>							
	No impairment	Mild impairment	Moderate impairment	Severe impairment	Complete impairment	Not specified	Not applicable
	0	1	2	3	4	8	9
b130	Energy and drive functions (G)						
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>General mental functions of physiological and psychological mechanisms that cause the individual to move towards satisfying specific needs and general goals in a persistent manner. Inclusions: functions of energy level, motivation, appetite, craving (including craving for substances that can be abused) and impulse control Exclusions: consciousness functions (b110); temperament and personality functions (b126); sleep functions (b134); psychomotor functions (b147); emotional functions (b152)</p> <p>Sources of information: <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation</p> <p>Description of the problem:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>							
	0	1	2	3	4	8	9
b134	Sleep functions						
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>General mental functions of periodic, reversible and selective physical and mental disengagement from one's immediate environment accompanied by characteristic physiological changes. Inclusions: functions of amount of sleeping, and onset, maintenance and quality of sleep; functions involving the sleep cycle, such as in insomnia, hypersomnia and narcolepsy Exclusions: consciousness functions (b110); energy and drive functions (b130); attention functions (b140); psychomotor functions (b147)</p> <p>Sources of information: <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation</p> <p>Description of the problem:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>							
	0	1	2	3	4	8	9
b152	Emotional functions (G)						
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Specific mental functions related to the feeling and affective components of the processes of the mind. Inclusions: functions of appropriateness of emotion, regulation and range of emotion; affect; sadness, happiness, love, fear, anger, hate, tension, anxiety, joy, sorrow; lability of emotion; flattening of affect Exclusions: temperament and personality functions (b126); energy and drive functions (b130)</p> <p>Sources of information: <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation</p> <p>Description of the problem:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>							
	0	1	2	3	4	8	9
b280	Sensation of pain (G)						
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Sensation of unpleasant feeling indicating potential or actual damage to some body structure. Inclusions: sensations of generalized or localized pain in one or more body part, pain in a dermatome, stabbing pain, burning pain, dull pain, aching pain; impairments such as myalgia, analgesia and hyperalgesia</p> <p>Sources of information: <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation</p> <p>Description of the problem:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>							

Reference Dr Werner Steiner 2002; Simon and Kraus de Camargo 2019, 72

Modified RPS-form (Rehabilitation Problem-Solving)



Date / Place

Participants in the meeting

Name

Main Goal

		Health condition			
		Strengths	Impairments	Strengths	Limitation / Restrictions
Person's (family's) perspective					
		Body functions and structures		Activities and participation	
(Inter)Professional perspective					
		Environmental factors		Personal factors	
		Facilitators	Barriers	Facilitators	Barriers
Person's (family's) perspective					



Primary source: Kraus de Camargo et al. (2019), appendix 4, p.162–166. Used with permission by Stefanus Snyman.

INTERPROFESSIONAL PERSON-CENTRED ASSESSMENT AND REFERRAL/DISCHARGE REPORT

1. Facility: _____

2. Name / _____ Gender: _____

Folder no: _____ Date of birth (age): _____

Address: _____ Occupation: _____

Tel: _____

3. **Current health problems / health conditions / health status**
(Including method of injury, onset, progression, previous treatment, medication)

4. **Medical history** *(e.g. chronic diseases, previous episodes, previous injuries)*

5. **Social history** *(e.g. social determinants of health, grants)*

6. Outcome level:	5: Productive activity	4: Community reintegration	3: Residential integration	2: Physiological maintenance	1: Physiological stability	0: Physiological instability
Initial assessment Date:						
Discharge / Referral Date:						

7. **Special investigations** *(HIV, TB, X-rays, etc.)*

8. **Reason for referral** *(if applicable)*

10. FUNCTIONING

Describe the relevant life areas according to how the person performs during an assessment and/or how the person performs in his/her usual environments (e.g. home, school, community, work).

Domain	Performance (strengths & restrictions)	Actions Needed/Taken:
Learning and applying knowledge (listening, learning, focusing attention, thinking, making decisions)		
General tasks & demands (undertaking single/multiple tasks, carrying out daily routine, handling stress)		
Communication (receiving and producing messages: spoken, nonverbal, formal sign language, written, devices)		
Mobility (changing and maintaining body position, carrying, objects, walking, moving using transport)		
Self-care (washing oneself, caring for body parts, toileting, dressing, eating, drinking, looking after health)		
Domestic life (acquisition of necessities, place to live, goods, preparing meals, household tasks, assisting others)		
Interpersonal interactions and relationships (formal, family, intimate relationships)		
Major life areas (education, work and employment, economic life)		
Community, social & civic life (community life, recreation, leisure, religion, spirituality, human rights, political)		

11. ENVIRONMENTAL FACTORS

Physical, social and attitudinal factors, external to the individual, that make it easier to function well (facilitators), or if present, are barriers to the way the person lives and conducts his/her life.

Domain	Facilitator (+) Barrier (-)	Actions Needed/Taken
Products & technology (for consumption (food, medication), for use in daily living, mobility, transport, education communication, employment, culture, etc.)		
Physical environment (neighbourhood, housing, sanitation, roads, light, noise, air quality, etc.)		
Support, relationships and attitudes (from immediate/extended family, friends, employer, health professionals, etc.)		
Services, systems and policies (health, housing, transportation, social security, labour, etc.)		

12. Personal factors (positive and negative) influencing health

Background of individual's life and living, which comprise features of the individual that are not part of a health condition or health states. These factors may include gender, race, age, other health conditions, fitness, lifestyle, habits, upbringing, coping styles, ideas, fears, expectations, social background, education, profession, past and current experience (past life events and concurrent events), overall behaviour pattern and character style, individual psychological assets and other characteristics, all or any of which may play a role in disability at any level.

13. PERSON-CENTRED GOAL SETTING AND SHARED DECISION-MAKING

Priority list / unresolved issues	Actions taken/needed

14	Name of Health Professional(s)	Signature	Professional number	Date and time:

The Patient-Specific Functional Scale

This useful questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopaedic condition.

Clinician to read and fill in below: Complete at the end of the history and prior to physical examination.

Initial Assessment:

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your _____ problem. Today, are there any activities that you are unable to do or having difficulty with because of your _____ problem? (Clinician: show scale to patient and have the patient rate each activity).

Follow-up Assessments:

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list at a time). Today, do you still have difficulty with: (read and have patient score each item in the list)?

Patient-specific activity scoring scheme (Point to one number):

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity						Able to perform activity at the same level as before injury or problem				

(Date and Score)

Activity	Initial						
1.							
2.							
3.							
4.							
5.							
Additional							
Additional							

Total score = sum of the activity scores/number of activities

Minimum detectable change (90%CI) for average score = 2 points

Minimum detectable change (90%CI) for single activity score = 3 points

PSFS developed by: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263.

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