Company Name

OCCUPATIONAL THERAPY EVALUATION

Patient Name:	MR #:
Type of Visit: ☐ **Initial Evaluation** ☐ **Re-Evaluation** ☐ **Resume of Care**	**Universal Precautions Followed:** ☐ Yes ☐ No

Homebound Status: *(Mark all that apply)* ☐ Pain with ambulation ☐ Requires assist from another to leave the home ☐ ↓Strength ☐ ↓Endurance ☐ ↓Balance ☐ Gait ataxia ☐ S.O.B. with minimal exertion ☐ Other: _____

Contraindications/Risk Factors: ☐ Falls ☐ Other: **Medical DX:**

Past Medical History:

Rehab. DX: **Cause of Injury:** *(document date)*

Vital Signs (PRN): ☐ HR _____ per minute resting _____ per minute with activity ☐ BP _____/_____ resting _____/_____ with activity

☐ Respirations: _____ per minute resting _____ per minute with activity

Scale: 1= Max Assist (75-100%) 2= Mod Assist (50-74%) 3= Min Assist (25-49%) 4= CGA/Sup. (1-24%) 5= Safe / Independent NA= Not Applicable

Activities of Daily Living	Prior	Current	Comments
Grooming			
Bathing			
Dressing UE			
Dressing LE			
Toileting			
Feeding			
Meal Preparation			
Ability to take Meds			
Light Laundry			
Light Housekeeping			
Money Management			
Telephone Management			
Kitchen Management			

Coordination:	Left	Right
Reach Overhead		
Reach behind n		
Reach behind back		
Hand to mouth		
Forearm sup/pro		
Grasp/Release		
Opp/Lateral		

UPPER EXTREMITY ASSESSMENT: Pinch

Location	Left ROM	Right	Weight Bearing	Left STRENGTH	Right
Hand					
Wrist					
Elbow					
Shoulder					
Other					

SCALE: 1= Severe (Dependent) 2= Moderate (Repetitive Verbal Cues/Physical Cues) 3= Mild (Verbal Cues/Supervision) 4= WFL (Independent)

LEVEL OF IMPAIRMENT:	Prior	Current	Comments
Sensation			
Attention Span			
Short Term Memory			
Long Term Memory			
Sequencing			
Judgement/Safety			
Problem Solving			
Functional Communication			
Level of Alertness			
Ability to Cooperate			

NEUROLOGICAL FINDINGS: ☐ N/A _____

VISION: ☐ Normal with / without visual aid ☐ Partially impaired with / without visual aid. Comments: _____

PAIN: Pt./cg. ☐ Instruction ☐ Return Demonstration. Grade: _____ / 10 at _____ (location) Pain being managed by: ☐ Meds. ☐ Modalities ☐ Exercise ☐ Other: _____

HOME ENVIRONMENT SAFETY ASSESSMENT: ☐ Bathroom/Shower ☐ Main Bedroom ☐ Hallways ☐ Kitchen ☐ Laundry Room ☐ Closets ☐ Garage ☐ Stairway ☐ Pt./cg. instructed in Fall Prevention

SOCIAL SITUATION: *(mark all that apply)* Pt. lives: ☐ Alone ☐ With private cg. ☐ With spouse ☐ With family

Comments/Recommendations: _____

AMBULATION: Pt./cg. ☐ Instruction ☐ Return demonstration Pt. ambulates independently or with _____ (device) with _____ assist. while performing ADL's/IADL's. Comments: _____

TRANSFERS: Pt./cg. ☐ Instruction ☐ Return Demonstration ☐ Supine to Sit _____ assist. ☐ Sit to Stand _____ assist.
☐ Bedside Commode _____ assist. ☐ Bed to Wheelchair _____ assist. ☐ Wheelchair to Commode _____ assist.
☐ Bathroom Commode _____ assist. ☐ Shower/Tub _____ assist. ☐ Car _____ assist. Comments: _____
ENDURANCE: Patient endurance is _____ /5. ☐ No SOB ☐ Pt. exhibits SOB with _____ ADL activities. SOB subsides with: ☐ Rest ☐ Other: _____ ☐ Pt./cg. educated in Energy Conservation Techniques. Comments: _____

FREQUENCY/DURATION: _____

OT ORDERS:

F01 ☐ Evaluation, progress/improve activities of daily
F03 ☐ Living, HEP
F04 ☐ Muscle re-education, improve fine motor movement;
F05 ☐ Perceptual motor training, edema control;
F06 ☐ Neuro-development treatment;
F07 ☐ Sensory treatment
F08 ☐ Wt. Bearing: progress L/R _____ from _____ to _____
F09 ☐ Progress ad MD permits / ☐ Progress to FWB as tolerated
F10 ☐ Safety precautions; coordination/balance;
F11 ☐ Orthotic/prosthetic training & management;
F12 ☐ Instruction / management of adaptive equipment
F13 ☐ Ultrasound _____ - _____ w/cm2 _____ min ☐ pulsed
F14 ☐ Continuous to _____ (location) as tol
F15 ☐ Cryotherapy to _____ (location) _____ min as tol
F16 ☐ Moist Heat to _____ (location) _____ min as tol
F17 ☐ Massage to _____ (location) _____ min as tol
F18 ☐ Other: _____

OT GOALS:

P01 ☐ The pt./cg. will perform home exercise program independently or with _____ assist within _____ wks.
P02 ☐ ROM of R / L _____ will increase from _____ degrees to _____ degrees / WFL's within _____ wks.
P03 ☐ Strength of R / L _____ extremity(s) will increase from _____ to _____ / 5 /WFL's within _____ wks.
P04 ☐ Pt. will be able to groom self independently or with _____ assist within _____ wks.
P05 ☐ Pt. / cg. will be able to dress upper body independently or with _____ assist within _____ wks.
P06 ☐ Pt. / cg. will be able to dress lower body independently or with _____ assist within _____ wks.
P07 ☐ Pt. / cg. will be able to bathe in shower independently or with _____ assist within _____ wks.
P08 ☐ Pt. / cg. will be able to perform all toileting independently or with _____ assist within _____ wks.
P09 ☐ Pt. will be able to feed self independently or with _____ assist within _____ wks.
P10 ☐ Pt. will be able to perform light IADL's (i.e. laundry/cleaning/shed) independently or with _____ assist within _____ wks.
P11 ☐ Pt. / cg. will be independent with pain management and pain will progress from _____ / 10 to _____ / 10 within _____ wks.
P12 ☐ (Low Vision Program) Home Safety Assessment category will improve from _____ to _____ risk for falls within _____ wks.
P13 ☐ Pt. will ambulate Ind. or with _____ (device) with _____ assist while performing ADL's / IADL's within _____ wks.
P14 ☐ OTHER:

OT REHAB. POTENTIAL: *(mark only one)*

1 ☐ Good for return to Independent
2 ☐ Good for partial return to function, patient will be able to perform independently
3 ☐ Good for partial return to function, patient will not be able to perform independently
4 ☐ Other: _____

DISCHARGE PLANS: *(mark only one)*

1 ☐ Patient will be discharged from OT when:
2 ☐ Goals are met; 3 ☐ Has returned to prior level of function;
4 ☐ Discharged to outpatient therapy 5 ☐ Other: _____

Other Skills Requested:

☐ PT ☐ ST ☐ MSW ☐ SN ☐ HHA Why: _____

Patient Involvement: ☐ Pt./cg. involved and agrees with set goals

☐ **PHYSICIAN** ☐ **SUPERVISOR Contacted:** ☐ Yes, notified of OT freq / orders / other skills requested Other Staff: ☐ PT
☐ PTA ☐ ST ☐ OTA ☐ MSW ☐ SN ☐ HHA Reason: _____

TREATMENT PERFORMED TODAY: *(mark all that apply)* ☐ Instruction in HEP, ☐ Pt. provided with HEP, ☐ Therapeutic Ex,
☐ Instruction in safety / precautions ☐ ADL training / education ☐ Other: _____

COTA:	Time In:	Time Out:

Patient Name _____ **Signature** _____ **Date** _____

Therapist Name _____ **Signature** _____ **Date** _____

My signature certifies this plan of care to be Medically Reasonable and Necessary

_____	_____	_____
Physician Name (print)	**Physician Signature**	**Date**