Elite

OCCUPATIONAL THERAPY EVALUATION

DATE OF SERVICE ___/___/___

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

TIME IN _____ OUT _____

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) _____

TYPE OF EVALUATION
☐ Initial ☐ Interim ☐ Final
SOC DATE ___/___/___
(If Initial Evaluation, complete Occupational Therapy Care Plan)

ORDERS FOR EVALUATION ONLY? ☐ Yes ☐ No If No, orders are _____

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEM _____

_____ ONSET ___/___/___

MEDICAL PRECAUTIONS _____

PRIOR LEVEL OF FUNCTION/WORK HISTORY _____

_____

LIVING SITUATION/SUPPORT SYSTEM _____

ENVIRONMENTAL BARRIERS _____

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED _____

KEY: I - Intact, MIN - Minimally Impaired, MOD - Moderately Impaired, S- Severely Impaired, U- Untested/Unable to Test

SENSORY/ PERCEPTUAL MOTOR SKILLS

Area	Sharp/Dull		Light/Firm Touch		Proprioception	
	Right	Left	Right	Left	Right	Left

VISUAL TRACKING:
R/L DISCRIMINATION:
MOTOR PLANNING PRAXIS:
Do sensory/perceptual impairments affect safety? ☐ Yes ☐ No
If Yes, recommendations:
COMMENTS:

COGNITIVE STATUS/COMPREHENSION

Area	I	MIN	MOD	S	U
MEMORY Short term					
Long term					
SAFETY AWARENESS					
JUDGMENT					
Visual Comprehension					
Auditory Comprehension					

ABILITY TO EXPRESS NEEDS
ATTENTION SPAN
ORIENTED: ☐ Person ☐ Place ☐ Time ☐ Reason for Therapy

PSYCHOSOCIAL WELL-BEING

INITIATION OF ACTIVITY
COPING SKILLS ☐ Evaluate Further
SELF-CONTROL

MOTOR COMPONENTS (Enter Appropriate Response)

Area	I	MIN	MOD	S	U		I	MIN	MOD	S	U
FINE MOTOR COORDINATION (R)						GROSS MOTOR COORDINATION (R)					
FINE MOTOR COORDINATION (L)						GROSS MOTOR COORDINATION (L)					

PRIOR TO INJURY: ☐ Right Handed ☐ Left Handed ORTHOSIS: ☐ Used ☐ Needed (Specify):

MUSCLE STRENGTH/ FUNCTIONAL ROM EVALUATION (Enter Appropriate Response)

PROBLEM AREA	STRENGTH		ROM		ROM TYPE			TONICITY		OTHER DESCRIPTIONS
	Right	Left	Right	Left	P	AA	A	Hyper	Hypo	

COMMENTS: _____

PATIENT/CLIENT NAME: Last, First, Middle Initial | ID #:

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OCCUPATIONAL THERAPY EVALUATION (Cont.)

FUNCTIONAL MOBILITY/BALANCE EVALUATION

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
BED MOBILITY			DYNAMIC SITTING BALANCE		
BED/WHEELCHAIR TRANSFER			STATIC SITTING BALANCE		
TOILET TRANSFER			STATIC STANDING BALANCE		
TUB/SHOWER TRANSFER			DYNAMIC STANDING BALANCE		

SELF CARE SKILLS

FEEDING			TOILETING		
SWALLOWING			BATHING		
FOOD TO MOUTH			UE DRESSING		
ORAL HYGIENE			LE DRESSING		
GROOMING			MANIPULATION OF FASTENERS		

INSTRUMENTAL ADL'S

LIGHT HOUSEKEEPING			USE OF TELEPHONE		
LIGHT MEAL PREPARATION			MONEY MANAGEMENT		
CLOTHING CARE			MEDICATION MANAGEMENT		

PATIENT GOALS:

PATIENT SIGNATURE VERIFYING VISIT:

Complete TIME OUT (on front) prior to signing here -->

THERAPIST SIGNATURE/TITLE _____ DATE ____/____/____

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance
4	Good strength - against gravity with some resistance.
3	Fair strength - against gravity - no resistance - safety compromise.
2	Poor strength - unable to move against gravity.
1	Trace strength - slight muscle contraction - no motion.
0	muscle contraction.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	100% active functional motion.
4	75% active functional motion.
3	50% active functional motion.
2	25% active functional motion.
1	Less than 25%.

FUNCTIONAL INDEPENDENCE, SELF-CARE SKILLS AND INSTRUMENTAL ADL SCALE

GRADE	DESCRIPTION
5	Physically able and does task independently.
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) - 100% patient/client effort.
2	Minimum assist (Min A) - 75% patient/client effort.
1	Maximum assist (Max A) - 25% - 50% patient/client effort.
0	Totally dependent - total

BALANCE SCALE (sitting-standing)

GRADE	DESCRIPTION
5	Independent
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) - 100% patient/client effort.
2	Minimum assist (Min A) - 75% patient/client effort.
1	Maximum assist (Max A) - 25% patient/client effort.
0	Totally dependent for support.

AVERAGE RANGES OF JOINT MOTION (ROM)

AREA	ACTION/ MOVEMENT			
Shoulder	Flex	158°	Extend	55°
	Abd.	170°	Add.	50°
	Int. rot.	70°	Ext. rot.	90°
Elbow	Flex	145°	Ext.	0°
Forearm	Sup.	85°	Pron.	70°
Wrist	Flex	73°	Ext.	70°
Fingers	Flex all	90°	Ext.	0°
Thumb	Abduction	50%		
Cervical Spine	Flex	35°	Ext.	35°
	Rotation	45°		

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OCCUPATIONAL THERAPY CARE PLAN

Physician orders needed. Follow organization procedure for obtaining verbal orders and completing the 485/POC

Patient Name: _____ MR #: _____ Date: _____ SOC Date: _____

Patient's address: _____ State/City/Zip: _____ Phone: _____

Diagnosis/Reason for OT.: _____

Physician's name: _____ Phone: _____ Fax: _____

Frequency and duration: _____ Insurance: ❑ Medicare ❑ Medicaid ❑ Other _____

OUTCOMES

Note: Each modality specify location, frequency, duration and amound.

Patient/Client Desired	Short Term - Time Frame	Lon Term - Time Frame

Plan of Care (Mark all applicable with

	Evaluation (Dl)		Neuro-developmental training (D7)		Body image training
	Establish rehab. Program		Sensory treatment (D8)		Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
■	Establish home exercise program ❑ copy given to patient/client ❑ copy attached to chart		Orthotics/splinting (D9)		
		■	Adaptive equipment (fabrication and training) (D10)		
	Patient/client/family education		Pain management		Other:
	Independent living/ADL training (D2)		Teach alternative bathing skills (unable to use tub/shower safely)		
	Muscle re-education (D3)	■			
	Perceptual motor training (D5)		Retraining of cognitive, feeding And perceptual skills		
	Fine motor coordination (D6)	■			

Equipment recommendations: _____

Safety issues/instruction/education: _____

Patient/client/caregiver response to plan of care: _____

GOALS: OCCUPATIONAL THERAPY

❑ Demonstrates ability to follow home exercise program by _____ (date).

❑ Demonstrates outcomes met by _____ (date).

❑ Other (specify)_____ by _____ (date).

REHAB POTENTIAL: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

DISCHARGE PLAN: ❑ When goals met ❑ Other (specify) _____

Comment _____

Plan developed by (name): _____ Signature/title: _____ Date _____

Plan of Care send with 485: ❑ Yes ❑ No Date send: _____