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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

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

INSTRUMENTAL ADL'S

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
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

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	Flex	35°	Ext.	35°
Spine	Rotation	45°		

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.

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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 (DI)		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)		Other:
	Patient/client/family education		Pain management		
	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: ______