

One staffing

OCCUPATIONAL THERAPY EVALUATION

DATE OF SERVICE / /
TIME IN OUT

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

HOMEBOUND REASON: <input type="checkbox"/> Needs assistance for all activities <input type="checkbox"/> Residual weakness <input type="checkbox"/> Requires assistance to ambulate <input type="checkbox"/> Confusion, unable to go out of home alone <input type="checkbox"/> Unable to safely leave home unassisted <input type="checkbox"/> Severe SOB, SOB upon exertion <input type="checkbox"/> Dependent upon adaptive device(s) <input type="checkbox"/> Medical restrictions <input type="checkbox"/> Other (specify) _____	TYPE OF EVALUATION <input type="checkbox"/> Initial <input type="checkbox"/> Interim <input type="checkbox"/> Final SOC DATE <u> </u> / <u> </u> / <u> </u> (If Initial Evaluation, complete Occupational Therapy Care Plan)
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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

Area	Sharp/Dull		Light/Firm Touch		Proprioception		VISUAL TRACKING:
	Right	Left	Right	Left	Right	Left	
							R/L DISCRIMINATION:
							MOTOR PLANNING PRAXIS:
							Do sensory/perceptual impairments affect safety? <input type="checkbox"/> Yes <input type="checkbox"/> No
							If Yes, recommendations:
							COMMENTS:

COGNITIVE STATUS/COMPREHENSION

Area	I	MIN	MOD	S	U	ABILITY TO EXPRESS NEEDS
MEMORY Short term						ATTENTION SPAN
Long term						ORIENTED: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Reason for Therapy
SAFETY AWARENESS						PSYCHOSOCIAL WELL-BEING
JUDGMENT						
Visual Comprehension						COPING SKILLS <input type="checkbox"/> Evaluate Further
Auditory Comprehension						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	Hvper	Hvpo	

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		FUNCTIONAL RANGE OF MOTION (ROM) SCALE	
GRADE	DESCRIPTION	GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance	5	100% active functional motion.
4	Good strength - against gravity with some resistance.	4	75% active functional motion.
3	Fair strength - against gravity - no resistance - safety compromise.	3	50% active functional motion.
2	Poor strength - unable to move against gravity.	2	25% active functional motion.
1	Trace strength - slight muscle contraction - no motion.	1	Less than 25%.
0	muscle contraction.		

FUNCTIONAL INDEPENDENCE, SELF-CARE SKILLS AND INSTRUMENTAL ADL SCALE		AVERAGE RANGES OF JOINT MOTION (ROM)				
GRADE	DESCRIPTION	AREA	ACTION/ MOVEMENT			
5	Physically able and does task independently.	Shoulder	Flex	158°	Extend	55°
4	Verbal cue (VC) only needed.		Abd.	170°	Add.	50°
3	Stand-by assist (SBA) - 100% patient/client effort.		Int. rot.	70°	Ext. rot.	90°
2	Minimum assist (Min A) - 75% patient/client effort.	Elbow	Flex	145°	Ext.	0°
1	Maximum assist (Max A) - 25% - 50% patient/client effort.	Forearm	Sup.	85°	Pron.	70°
0	Totally dependent - total	Wrist	Flex	73°	Ext.	70°
		Fingers	Flex all	90°	Ext.	0°
		Thumb	Abduction	50%		
		Cervical	Flex	36°	Ext.	36°
		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 amount.

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

Plan of Care (Mark all applicable with

<input type="checkbox"/> Evaluation (D1)	<input type="checkbox"/> Neuro-developmental training (D7)	<input type="checkbox"/> Body image training
<input type="checkbox"/> Establish rehab. Program	<input type="checkbox"/> Sensory treatment (D8)	<input type="checkbox"/> Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
<input type="checkbox"/> Establish home exercise program <input type="checkbox"/> copy given to patient/client <input type="checkbox"/> copy attached to chart	<input type="checkbox"/> Orthotics/splinting (D9) <input type="checkbox"/> Adaptive equipment (fabrication and training) (D10)	<input type="checkbox"/> Other:
<input type="checkbox"/> Patient/client/family education	<input type="checkbox"/> Pain management	
<input type="checkbox"/> Independent living/ADL training (D2)	<input type="checkbox"/> Teach alternative bathing skills (unable to use tub/shower safely)	
<input type="checkbox"/> Muscle re-education (D3)	<input type="checkbox"/> Retraining of cognitive, feeding And perceptual skills	
<input type="checkbox"/> Perceptual motor training (D5)		
<input type="checkbox"/> 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: _____