REGAL HOME SERVICES

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PT/OT EVALUATION

PATIENT'S NAME: ______________________ DATE: __________ TIME (IN & OUT) __________

DIAGNOSIS: __________ ALLERGIES: __________ DIET: __________ MEDICATION __________

MENTAL/SENSORY FUNCTION: ______________________

PERTINENT HISTORY OF PRESENT ILLNESS: ______________________

____

FUNCTIONAL STATUS: (Indicate appropriate assistance level below (1=Max 2=Mod 3= Min 4= Indep)

BED MOBILITY	TRANSFERS	ADLS	AMBULATION	BALANCE
Rolls, Turn (RT) ___ (LT) ___ Moves Sideways (RT) ___ (LT) ___ Comes to Sit ___ Wheelchair Mobility ___ N/A ___ Good ___ Fair ___ Poor	Supine to/from sit ___ Stand to/from bed ___ Stand to/from Toilet ___ Stand to/from Chair ___ Sit to/from Toilet ___ Tub/Shower ___ Wheelchair ___	Groom Self ___ Feeds self ___ Dresses self ___ Bathes self ___	Comes to standing ___ Maintains Balance ___ Coordination ___ Endurance ___ Weight bearing ___ Stair climbing ___	Static Sit ___ Static Stand ___ Dynamic Sits ___ Dynamic Stands ___ Sensation ___

	ROM	STRENGTH	COORDINATION	EDEMA	SKIN INTEGRITY
RUE					
LUE					
RLE					
LLE					
NECK/TRUNK					

COMMENTS: ______________________

____

____

PRIOR FUNCTIONAL STATUS: ______________________

HOME THERAPY DUE TO: ______________________

GAIT EVAL/ASSISTIVE DEVISES: ______________________

ENVIRONMENT/SAFETY EVAL: ______________________

____

PAIN STATUS: __0 __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

EFFECTIVENESS OF PAIN RELIEF MEASURES: ___ Good ___ Fair ___ Poor

LOCATION: ______________________

IS THERE A CHANGE IN PAIN: ___ No ___ Yes Explain: ______________________

Describe pain relief measures used by patient: ______________________

REASON CODE FOR COMPROMISED FUNCTION:
__ (B) Poor Balance __ (C) Coordination __ (D) Dysprica __ (W) Weakness __ (A) Anxiety/Fear __ (R) Loss of ROM
__ (M) Poor Postural/Body Mechanics __ (P) Pain __ (G) Cognitive Deficit

INTERVENTIONS:

Therapeutic Exercises: (Record # of reps in the ___ after each exercise)

Types: __ AROM __ AARM __ PROM __ Resistive __ Other: ____________________

Supine ☐ SLRs ____ ☐ Heel Slides ___ ☐ Knee-chest ___ ☐ Ankle Pumps ___ ☐ Hip ab/ad ___
☐ Bridges ____ ☐ Trunk Rotations ___ ☐ Push Ups ___ ☐ Sit Ups ___

Standing ☐ Marches ____ ☐ Semi Squats ___ ☐ Hip ab/ad ___ ☐ Hip back ext ___ ☐ Toe raises ___
☐ Ant/Post Wt shift ___ ☐ Medial/Lateral wt shift ___

Sitting ☐ Knee raises ___ ☐ Long arc quads ___ ☐ Abductor squeeze ___ ☐ Ankle Pumps ___

Balance ☐ Tangent walking ___ ☐ Side Stepping ___ ☐ Standing eyes closed ___ ☐ Bridging ___
☐ Backwards walking ___ ☐ Unilateral Stance ___

INSTRUCTIONS: (check instructions that were given and add details below)

☐ Gait Training
☐ Fall Prevention
☐ Safety Instruct.
☐ Pulmonary PT
☐ Hip Safety precautions/ Joint replacement precautions
☐ Prosthetic Training
☐ Transfer Training
☐ Muscle re-education
☐ Cardiopulmonary PT
☐ Written materials presented to patient/caregiver
☐ Pre-prosthetic training
☐ Strength training
☐ Bed Mobility Skills
☐ Energy Conservation
☐ Safe/effective use of adaptive device
☐ Balance training/activities
☐ Functional mobility training
☐ Monitoring of vitals with exercise
☐ Home Exercise program
☐ Positioning for comfort/pressure relief

COMMENTS: ____

PROBLEM	SHORT TERM GOAL	TREATMENT RENDERED	EVALUATION

LONG TERM GOALS/DISCHARGE PLAN: ____

WAS HOME CARE PLAN DISCUSSED WITH PATIENT? __ Yes __ No
Treatment Frequency: ______________ Treatment Duration: ______________

CONTACT MADE WITH OTHERS? __ Yes __ No (If yes, who?) ______________
What was discussed: ____

REHAB POTENTIAL TO ACHIEVE GOALS AS STATED: __ Excellent __ Good __ Fair __ Poor