

# OCCUPATIONAL THERAPY EVALUATION

DATE OF SERVICE      /      /       
TIME IN      OUT     

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

**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		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						<b>PSYCHOSOCIAL WELL-BEING</b>
JUDGMENT						INITIATION OF ACTIVITY
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	Hyper	Hypo	

COMMENTS: \_\_\_\_\_

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

# 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°
BALANCE SCALE (sitting-standing)			Thumb	Abduction	50%		
GRADE	DESCRIPTION		Cervical	Flex	35°	Ext.	35°
5	Independent		Spine	Rotation	45°		
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.						

# 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: \_\_\_\_\_