OCCUPATIONAL THERAPY EVALUATION

☐ Initial Evaluation
☐ Re-Evaluation (Type)_____

☐ G5001: Hospice or Home Health Care provided in patient's home/residence
☐ G5002: Hospice or Home Health Care provided in Assisted Living Facility
☐ G5009: Hospice or Home Health Care provided in place not otherwise specified

DATE OF SERVICE ____/____/____
TIME IN_____ TIME 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)_____

SOC DATE____/____/____
☐ G0152 ☐ G0160 Maintenance

PERTINENT MEDICAL INFORMATION

Onset Date:____/____/____ **Primary Diagnosis:**_____
Medical Precautions/Limitations:_____

Vital Signs: Temp:_____ Pulse:_____ Regular / Irregular
Resp.:_____ B/P:_____ Using O_2 at _____LPM via:_____
Pain:
Rating scale: 0 (No pain) 1 2 3 4 5 6 (Mod pain) 7 8 9 10 (Worst pain) Current pain level:_____ (subjective reporting)
Pain quality:_____ (achn, sharp, dull, etc.) Pain location:_____
Frequency: ☐ Occasionally ☐ Continuous ☐ Intermittent ☐ Other_____
What makes pain worse? ☐ Movement ☐ Ambulation ☐ Immobility
Referral needed? ☐ Yes ☐ No Referred to:_____
Impacting function? ☐ Yes ☐ No (specify)_____
POC Goal Needed? ☐ Yes ☐ No

PERTINENT BACKGROUND INFORMATION

Prior Level of Functioning With ADLs:
☐ Independent ☐ Needed assist ☐ Total assist
History of Falls:
☐ Yes ☐ No If yes, date of last fall: ____/____/____
Intervention in place? ☐ Yes ☐ No
If yes, specify:_____
Reported by: ☐ Patient ☐ Family ☐ Caregiver
Support System:
☐ Lives alone ☐ Caregiver available
☐ Limited support ☐ No caregiver available
Comment:_____
Environmental Barriers: ☐ Clutter ☐ Throw rugs
Adaptive equipment needed: ☐ Yes ☐ No
(type)_____
Other:_____

SENSORY/PERCEPTUAL MOTOR SKILLS

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

Visual Skills: Acuity: ☐ Intact ☐ Impaired ☐ Double ☐ Blurred
Tracking: ☐ Unilaterally ☐ Bilaterally ☐ Smooth ☐ Jumpy ☐ Not Tracking
Visual Field Cut or Neglect Suspected: ☐ Right ☐ Left
Impacting Function? ☐ Yes ☐ No (specify)_____
Referral Needed? ☐ Yes ☐ No Who contacted?_____
POC Goal Needed? ☐ Yes ☐ No

COGNITIVE STATUS/COMPREHENSION

ORIENTED: ☐ Person ☐ Place ☐ Time ☐ Reason for Therapy_____

Deficit Area	Impaired	Intact	Functional	Deficit Area	Impaired	Intact	Functional
MEMORY: Short term				Sequencing			
Long term				Problem Solving			
Attention/Concentration				Coping Skills			
Auditory Comprehension				Able to Express Needs			
Visual Comprehension				Safety/Judgment			
Self-Control				Initiation of Activity			

Impacting function? ☐ Yes ☐ No (specify)_____ **POC Goal Needed?** ☐ Yes ☐ No

MOTOR COMPONENTS (Enter Appropriate Response)

Fine Motor Coordination	Impaired	Intact	Functional	Gross Motor Coordination	Impaired	Intact	Functional
Right				Right			
Left				Left			

☐ Right handed ☐ Left handed
☐ Orthosis ☐ Used ☐ Needed (specify)_____
☐ Impacting function? ☐ Yes ☐ No (specify)_____ **POC Goal Needed?** ☐ Yes ☐ No

PATIENT NAME – Last, First, Middle Initial | ID#

STRENGTH/ROM/TONE/EDEMA (Enter Appropriate Response)

Extremity	Strength (MMT)		AROM Measure		PROM Measure	
	Right	Left	Right	Left	Right	Left
Shoulder Flexion						
Shoulder Abduction						
Shoulder Adduction						
Elbow Flexion						
Elbow Extension						
Wrist Flexion						
Wrist Extension						
Supination						
Pronation						
Finger MCP's						

Tone: ☐ Normal ☐ Abnormal (specify):_____

Edema: ☐ Normal ☐ Abnormal (specify):_____

Impacting function? ☐ Yes ☐ No (specify)_____ POC Goal Needed? ☐ Yes ☐ No

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	Zero - no active 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 SCALE FOR Balance/Mobility/Self Care/ADL's/Instrumental ADL's

GRADE	DESCRIPTION
7	Independent.
6	Modified independent - verbal cues, extra time.
5	Stand-by assist (SBA) - 100% effort w/supervision.
4	Minimal assist - 75% effort.
3	Moderate assist - 25-50% effort.
2	Maximum assist - 25% effort.
1	Dependent/unable to do task <25% effort.

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
FUNCTIONAL MOBILITY/BALANCE EVALUATION					
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/ADL SKILLS					
SELF FEEDING			UB BATHING		
SWALLOWING			LB BATHING		
ORAL HYGIENE			UB DRESSING		
GROOMING			LB DRESSING		
TOILETING			FASTENERS		
INSTRUMENTAL ADL'S					
HOUSEKEEPING			TELEPHONE USE		
MEAL PREPARATION			MONEY MANAGEMENT		
LAUNDRY			MEDICATION MANAGEMENT		

Adaptive devices in place? ☐ Yes ☐ No (specify)_____

Impacting function? ☐ Yes ☐ No (specify)_____ POC Goal Needed? ☐ Yes ☐ No

Impacting function? ☐ Yes ☐ No (specify)_____ POC Goal Needed? ☐ Yes ☐ No

OCCUPATIONAL THERAPY CARE PLAN

SOC DATE____/____/____

Primary Diagnosis_____ Onset Date:____/____/____

Treatment Diagnosis/Problem Areas:

- ☐ Coordination deficits (Fine/Gross)
- ☐ Upper body weakness/limited ROM
- ☐ Visual disturbances/deficits/limitations
- ☐ Cognition (memory, orient, etc.)
- ☐ Difficulty with dressing/bathing/grooming/hygiene/toileting
- ☐ Difficulty with homemaking skills/money management/laundry/meal prep
- ☐ Impaired attention/concentration/problem solving, sequencing
- ☐ Other:_____

Frequency and Duration:_____

OCCUPATIONAL THERAPY INTERVENTIONS (check or circle all that apply)

- ☐ Establish HEP: ☐ Given to Pt. ☐ In Chart
- ☐ Patient Education
- ☐ Family/Caregiver Education
- ☐ Environmental Barriers specify)_____
- ☐ Activities of Daily Living
- ☐ Instrumental Activities of Daily Living
- ☐ Therapeutic Exercise
- ☐ Neuro-Muscular Re-education
- ☐ Therapeutic Activity
- ☐ Cognition
- ☐ Adaptive Equipment Training
- ☐ Visual/Perceptual Skills
- ☐ Sensory Integration/Stimulation
- ☐ Splinting (fabrication/modification)
- ☐ Other:_____

GOALS/OUTCOMES: Patient/Therapist identified functional based goals (areas identified in evaluation)

Functional Goal Area Identified at Eval:	Functional Short Term Goal #1: Measurable and date by:____/____/____	Functional Long Term Goal #1: Measurable and date by:____/____/____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #2: Measurable and date by:____/____/____	Functional Long Term Goal #2: Measurable and date by:____/____/____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #3: Measurable and date by:____/____/____	Functional Long Term Goal #3: Measurable and date by:____/____/____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #4: Measurable and date by:____/____/____	Functional Long Term Goal #4: Measurable and date by:____/____/____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #5: Measurable and date by:____/____/____	Functional Long Term Goal #5: Measurable and date by:____/____/____

Adaptive equipment needs identified? ☐ Yes ☐ No If Yes (specify)_____

Patient/Family/Caregiver aware and in agreement of POC? ☐ Yes ☐ No If No (specify)_____

Discharge Plan: ☐ When goals are met ☐ Other:_____

Comments:_____

Patient Signature X

Demonstrates Rehab Potential: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Patient demonstrates potential for continued gains towards a greater level of functional independence and will benefit from continued Occupational Therapy Services to address deficit areas impacting his/her function. Please see Occupational Therapy Evaluation and Plan of Care for further detailed information regarding current functional level and areas of focus.

OTR

Plan developed by: X_____ Date:_____

Professional signature/title

Occupational Therapy Care Plan and Physician Orders

NOTE: To be used ONLY For Supplemental Orders to Plan of Care/485 for Therapy Services.

When patient under hospice POC, the IDT determines changes to the POC with the medical director and/or attending physician.

Recommended Plan, Outcomes, Frequency & Duration as above.

Verbal orders from physician by:_____ Date:_____

Professional signature/title

Physician signature:_____ Date:_____

Please sign and return promptly

Original - Physician Copy - Clinical Record (until signed original returned)

PATIENT NAME