**Visit Length:**

An evaluation of this was requested by to assess:

**Diagnoses** known presently include:

**Other factors impacting function** include:

**Prior Level of function**:

**Currently living in**  **with**:

**Current Functional Status**:

Mobility

Cognition

Mental health

Financial

ADLs

Sensory/ pain

Socialization

**Treatment provided today**:

**Assessment:**

**Problem List:**

**Recommendations:**

**Plan:** Frequency, Duration

**Long Term Goal:**

**GOALS:**

**PATIENT SPECIFIC FUNCTIONAL SCALE The secondary might be Medicare, please pick a G-CODE area from this list, this table will provide the rest of the needed data:** Mobility, Position, Handling, Self-Care, Other, Swallow, Attention, Memory, Motor Speech, Spoken Language Comp, Spoken Language Expr, Voice

|  |  |  |  |
| --- | --- | --- | --- |
| I’m going to ask you to identify up to **three important activities and areas of participation** that you are unable to do or are having difficulty with as a result of the problems you described. 10 = unable 0 = fully able (This is not a problem list, these are areas of engagement, what the client DOES that is not up to par.) Convert the 0-10 scale to %: i.e. 3 = 30% | We may want to compare how you’re doing after therapy, so on a scale of 0 to 10, (10 = unable to do activity), **HOW MUCH does this problem interfere with the activities or participation?**  | You, therapists, list your goal for each area (0 = fully able) | **At D/C or re-eval**Today how would you rank the original activities (see column 1) we first discussed from 0 to 10 (0 = fully able) |
| 1. 2. 3.  | 1. 2. 3.  | 1. 2. 3.  | 1.2.3. |
| **Totals:  add scores and divide by # activities:  i.e. If scores were 2 + 4 + 1 = 7, (or 20 + 40 + 10 = 70) divide by 3 activities, would be: 70/3 = 23%** | **Total:**  |  **Total:**  | **Total:** |
| EVAL QUESTION: **How will you know if your therapy with us is making a difference?**  |
| PERIODIC QUESTION: **How is your therapy with us is making a difference?** Document this in progress notes |

**Therapist Signature: Date:**

**CERIFICATION OF PLAN OF CARE BY MD:**

**\_\_\_\_** I agree with this plan and the medical information is complete.

\_\_\_\_ Other medical issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ I disagree with this plan because \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Physician’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Please fax this information to confidential fax: 877-334-0714**