|  |  |
| --- | --- |
| This is Out-Patient in the home. Patient does not need to be homebound.  | THERAPY IN YOUR HOME We provide Out-Patient therapy at home |
|  Ambulates: 1-10 feet 10-25 feet 25-50 feet greater than 50 feet |  Occupational Therapy Assessment |
|  With: No device Walker Cane Crutches  |  408-358-0201 FAX: 877-334-0714  |
|  Assist: Standby Min Mod Max | Office@TherapyInYourHome.net |
| Taxing Effort: Poor Balance Pain Lack of Endurance | PATIENT NAME:  |
|  Dyspnea Unsteady Gait Dizziness | Patient Signature: |
|  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient is essentially bedbound Sex: M FPrecautions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surgical Procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Medicare MediCal Private Insurance  Private Pay   Workers’ Com OtherCase Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Others involved in care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Prior Level of Function:** |

 **UPPER EXTREMITY and TRUNK Neuromusculoskeletal Functions:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Muscle functions: tone, strength, endurance** | **Strength R** | **Strength L** | **Joint functions: stability, alignment, range** | **R** | **L** | **Grade** | **MMT MUSCLE STRENGTH** |
| Shoulder |  |  | Flexion/Extension |  |  | 5 | Normal strength-against gravity-full resistance |
|  |  |  | Abduction/Adduction |  |  | 4 | Good strength-against gravity-some resistance |
|  |  |  | Int. Rot. / Ext. Rot. |  |  | 3 | Fair strength-against gravity-safety compromised |
| Elbow |  |  | Flexion/Extension |  |  | 2 | Poor strength- full active ROM-without gravity |
| Forearm |  |  | Supination/Pronation |  |  | 1 | Trace strength-slight muscle contraction-no motion |
| Wrist |  |  | Flexion/Extension |  |  | 0 | No active muscle contraction |
| Fingers |  |  | Flexion/Extension |  |  |  | **JOINT FUNCTION SCALE** |
| Trunk/Postural Control |  |  |  |  |  | 5 | 100% active functional motion |
| Comments: |  |  |  |  |  | 4 | 75% active functional motion |
|  |  |  |  |  |  | 3 | 50% active functional motion |
|  |  |  |  |  |  | 2 | 25% active functional motion  |
|  |  |  |  |  |  | 1 | Less than 25% active functional motion |
|  |  |  |  |  |  | 0 | 0 active functional motion |

 **PAIN and Vital Signs:**  BP:\_\_\_/\_\_\_; O2:\_\_\_\_; Temp: \_\_\_\_; Pulse:\_\_\_; Edema\_\_\_\_\_\_\_\_\_\_\_\_\_; Wound status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 Pain reported Denied Pain/None reported Intractable Pain: Yes No

 Pain Level (on 1-10 scale): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency/Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type/Description of Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relief Method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effectiveness of Pain Management: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **COGNITIVE / SENSORY / PERCEPTUAL FUNCTIONS**:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|   | Intact | Impaired |  |  |  Intact | Impaired |
|  Alertness  |  |  |  | Problem Solving |  |  |
|  Oriented to person, place and time |  |  |  | Initiation |  |  |
|  Attention span |  |  |  | Sequencing |  |  |
|  Direction Following |  |  |  | Completion |  |  |
|  Memory  |  |  |  | Organization |  |  |
|  Communication |  |  |  | Safety Awareness |  |  |
|  Error Recognition |  |  |  | Judgment |  |  |

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Intact** | **Impaired** | **Comments** |
| Hearing |  |  |  |
| Visual / Perceptual Skills |  |  |  |
| Sensation / Proprioception |  |  |  |
| Motor Planning  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 7 | Complete Independence (timely, safe) | 4 | Minimal Assistance (patient = 75%+) | 1 | Total Assistance (patient = 0%) |
| 6 | Modified Independence (device needed) | 3 | Moderate Assistance (patient = 50%+) | NT | Not Tested |
| 5 | Stand By Assistance / Supervision | 2 | Maximal Assistance (patient =25%+) | NA  | Not Applicable |

# ACTIVITIES OF DAILY LIVING

|  |  |  |
| --- | --- | --- |
| DESCRIPTION | FUNCTIONALSTATUS | **COMMENTS** |
| **Feeding:** |  | Diet: |
|  Oral-Motor |  |  |
|  Hand to Mouth |  |  |
| **Toileting:** |  |  |
|  Bladder Continence |  |  |
|  Bowel Continence |  |  |
|  Hygiene |  |  |
|  Clothing Management |  |  |
|  Transfer: Toilet / Commode |  |  |
| **Dressing:** |  |  |
|  Upper Body |  |  |
|  Lower Body |  |  |
|  Brace / Prosthesis |  |  |
| **Bathing:** |  |  |
|  Sponge Bath |  |  |
|  Bathing |  |  |
|  Transfer: Tub / Shower |  |  |
| **Grooming / Hygiene:** |  |  |
|  Hair Care |  |  |
|  Oral Hygiene |  |  |
|  Shaving: Face / Legs |  |  |
| **Meal Prep Activities:** |  |  |
|  Meal Prep and Clean Up |  |  |
|  Use Appliances |  |  |
|  Reach Cabinets |  |  |
|  Transfer Items |  |  |
|  Identify & Place Shopping Order |  |  |
| **Home Management:** |  |  |
|  Telephone Use |  |  |
|  Laundry |  |  |
|  General Housekeeping |  |  |
|  Garbage |  |  |
|  Care of Others & Pets |  |  |
|  Financial Management |  |  |
| **Emergency Plans:** |  |  |
|  Ability to Call for Help |  |  |
|  Ability to Exit Home |  |  |
| Knowledge of/Access to Community Resources / Health Info Related to Diagnosis |  |  |

**Other areas:**

**ENVIRONMENTAL**

Description of Living Situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments regarding safety and appropriateness of equipment, architectural barriers, social support: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL SUPPORT**: Patient lives: Alone With Spouse / Significant Other With Relatives Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Present for Evaluation

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ability to Manage Care: Physically: Yes No Mentally: Yes  No, Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plans for Community Mobility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

They gave Med List? \_\_, they understand meds?\_\_, take appropriately?\_\_\_; Falls:\_\_#/per \_\_\_; causes (mechanical / non mech); POC addresses falls?

Depression tested? Using?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKILLED CARE PROVIDED**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT / CAREGIVER RESPONSE**: Other community support needed?: Yes\_\_\_No\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLAN: FREQUENCY / DURATION (# months):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Treatment plan approved by patient/caregiver: Yes No;

**PATIENT SPECIFIC FUNCTIONAL SCALE**

|  |  |  |  |
| --- | --- | --- | --- |
| I am 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) | When I assessed you on (date) you told me that you had difficulty with (read activities). **Today do you still have trouble with (read and score each activity).**  |
| 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: |

**Discharge Plan** **Discussed with Patient / Caregiver:** Yes No; Describe how you will know when to stop:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMUNICATIONS:** More care needed than covered by Medicare / Insurance? Yes No; If so an ABN may be needed. When?\_\_\_\_\_\_\_\_\_

Name ofM.D. Contacted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Communications with: RN Case Manager Family Physical Therapist Speech Therapist MSW HHA Other

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Re:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other comments:­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CERIFICATION OF PLAN OF CARE:**

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

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Physician’s Name Date**

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