An evaluation of this \_\_\_\_\_\_ year-old was requested by:

to assess:

**Diagnoses** known at this time include:

**Other factors impacting function** include:

**Prior Level of function**:

Currently living in with:

**Current Functional Status**:

Swallow

Cognition

Motor Speech

Dysphagia

Language

Read / Write

Ears / Eyes

Sensory/ pain

Socialization

Finances

**Treatment provided today**:

**Assessment:**

**Problem List:**

**Recommendations:**

**Plan:** **Frequency, Duration**

**SHORT TERM GOALS:** What performance will change; measured how, with how much help, under what conditions, for how long.

**LONG TERM GOAL:**

**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 Signature**

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