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

 ADLs

 Cognition

 Sensory /pain

 Mental health

 Socialization

 Financial

**Treatment provided today:**

**Assessment:**

**Problem List:**

**Recommendations:**

**Plan:** Frequency, Duration (2 months, unless otherwise stated)

**Long Term Goal:**

**PATIENT SPECIFIC FUNCTIONAL SCALE (If Medicare add G-CODE area from** 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 **This % goes in box A on grid** 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?**  | **What is the GOAL for each area on a scale of 0 – 10****0 = fully able** | **10th Visit or D/C How do you rank the original activities today:****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:** **This % goes in box A on grid** |  **Total:** **This % goes in Boxes B & C on grid**  | **Total:****This % goes in box D on grid** |
| 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**