|  |  |
| --- | --- |
| 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 F  Precautions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Secondary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Surgical Procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicare MediCal Private Insurance  Private Pay   Workers’ Com Other  Case 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 |  |  |  |

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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:** \_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Treatment plan approved by patient/caregiver: Yes No;

**PATIENT SPECIFIC FUNCTIONAL SCALE** G code area\_\_\_\_\_(Pick from: Mob, Position, Handling, Self-Care, Other, Swallow, Attention, Memory, Motor Speech, Spoken Language Comp, Spoken Language Expr, Voice)

|  |  |  |  |
| --- | --- | --- | --- |
| 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:  **This % goes in box A on grid** | Total:  **This % goes in box B & C on grid** | Total:  **This % goes in box D on grid** |

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

**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 Signature**

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

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