**Evaluation referred by, to assess: Visit Length:**

Medical and treatment diagnosis

Current living situation:

Other factors impacting function:

Prior Level of function:

**ROM and STRENGTH:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Joint or Muscle group** |  **R** **ROM** | **L****ROM** | **R****Strength** | **L Strength** | **Muscle functions: tone, strength, endurance** | **Joint functions: stability, alignment, range** | **Comments /areas of concern** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

 **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  |  |  |  |

**CURRENT FUNCTIONAL STATUS**

 Mobility

ADLs

Cognition

 Sensory /pain

 Mental health

 Socialization

 Financial

 Medication Management

**Treatment provided today and response**:

**ASSESSMENT**:

**Short term Goal: PATIENT SPECIFIC FUNCTIONAL SCALE: Add G-CODE area to grid from one of the following:**

Mobility, Position, Handling, Self-Care, Other, Swallow, Attention, Memory, Motor Speech,

Spoken Language Comp, Spoken Language Expr, Voice

|  |  |  |  |
| --- | --- | --- | --- |
| This is not a problem list, these are areas of engagement or function: What the client is UNABLE TO DO that is not up to par. **Pick one or two, or add others if needed.**  | HOW MUCH does this problem interfere with activities or participation?  | Therapist’s goal.  |  **10th visit or** DC Status:  |
| 1. Unable to do\_\_\_\_\_ because of
2. Lacks confidence to \_\_\_\_\_\_
3. Takes extra time to \_\_\_\_\_\_\_
4. Makes poor judgment about \_\_\_\_\_\_
5. Does not follow through with\_\_\_\_\_
6. Has pain while \_\_\_\_\_\_
7. Has low energy or endurance for \_\_\_\_\_
8. CG needs \_\_\_\_\_\_\_\_\_
9. Home needs\_\_\_\_\_\_
10. Other
 | 100% impaired to 0% impairedA. B. C. D.E.F.GH.I. J | 100% to 0% impairedA. B. C. D. E.F.G.H.I.J.  | 100% to 0% impairedA. B.C.D.E.F. |
| **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 |

**LONG TERM GOAL**:

**FREQUENCY**: \_\_\_\_ x’s per week or month **DURATION**: \_\_\_\_ # of weeks

**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 1-4-19**

**information to confidential fax: 877-334-0714 01/04/19**