**An evaluation of this** was requested by to assess:

**Diagnoses** known presently include**:**

**Other factors impacting function include:**

**Prior Level of function and education and social skills:**

**Currently living in** with

**Current Functional Status – assessment and observation:**

 **Articulation and phonology**

 **Language**

 **Auditory comprehension**

 **Expressive skills**

 **Voice**

 **Fluency**

 **Pragmatics**

 **Visual skills**

 **Cognition**

 **Swallow**

 Mobility ADLS, Pain,

 Financial

 Social support

**Assessment**:

**Treatment provided today:**

**Problem List**:

**Recommendations:**

**Plan: Frequency, Duration:**

**Long 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

|  |  |  |  |
| --- | --- | --- | --- |
| **Identify up to three important activities or areas of engagement that you are unable to do or are having difficulty doing as a result of the problems you described.**  | **On Scale of 0-10, how much does this problem interfere with the activities or participation?** 10 = unable to do activity 0 = fully able to do activityConvert the 0-10 scale to %: i.e. 3 = 30% | **Therapist’s goal**. 10 = unable; 0 = fully able. Convert the 0-10 scale to %: i.e.: 3 =30% | **10th Visit or D/C** **Today, on Scale of 0-10, how would you rank the original activities**  (0 = fully able, convert to percent)  |
| 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: Patient Name:**

**\_\_\_\_** **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 1-4-19**