**DATE: \_\_\_\_\_\_\_\_\_\_** Visit length\_\_\_\_\_\_ Discipline:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  | **OCCUPATIONAL THERAPY EVALUATION** |
|  | **OCCUPATIONAL THERAPY re-EVALUATION** |

Diagnosis as listed in patient chart, with the following relevant information:

(precautions, old injuries, social/emotional/financial status, past level of function and interests)

Prior level of function and living situation:

**Current Level of Function**

Bed Mobility

Bathroom Mobility

Ability to get out of room

ROM / Strength / limits

Pain

ADL level of assist:

Cognition: safety awareness, initiation, follow-through, self-advocacy

Engagement in exercise, mobility, activity options, visitors

Self Feeding

ASSESSMENT:

**PLAN:**

Occupational Therapy FREQUENCY: \_\_\_\_\_\_\_\_\_\_ x’s per week or month

DURATION: \_\_\_\_\_\_\_\_\_\_\_ # of weeks ( up to the two-month certification period. OK to go over two months after talking with TIYH. OK to put on hold. Include in your plan)

\_\_\_ Therapy training of facility aides expected to occur \_\_\_\_\_\_\_\_\_\_\_\_; may cover: \_\_\_safety;

\_\_\_ transfers; \_\_\_ feeding; \_\_\_ ADLS; \_\_\_engagement; \_\_\_ using appropriate cues;

\_\_\_ ideas for cues/language; \_\_\_other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Therapy training of family or engagement of other community support: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_

**LONG TERM GOAL**:

**SHORT TERM GOAL:**

What performance will change; measured how, with how much help, under what conditions, for how long (Pick two or three goals, below)

Able to

Has confidence to do

Can complete tasks with sufficient consistency, flexibility and efficiency

Uses judgement to

Follows through with

Keeps pain at

Has activity tolerance to

Environment allows

Caregiver able to

Other

**Therapist Signature:** **Date:**

**CERTIFICATION 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 Signature**

**\*\*Please fax this information to confidential fax: 877-334-0714 2-18-19**