Visit Length:

**Evaluation referred by:**  **to assess:**

Medical and treatment diagnosis:

Other factors impacting function:

Prior level of function:

**CURRENT LEVEL OF FUNCTION:**

**CURRENTLY LIVING** in with

**MOBILITY and BALANCE:** (i.e.: car, floor, bed, uneven surfaces, community. Safety, activity tolerance, assistive devices. Confidence, knowledge of mobility and balance management)

**ADLS and IADLS:** (i.e.: dressing, toileting, bathing, grooming, meal prep, telephone, laundry, housekeeping, garbage, pets, finances, medications, continence, feeding and swallowing, caregiver management, carry items, writing, call for help, exit home, access community resources, shop, organize papers)

**QUALITY OF LIFE**: (i.e.: Mental health, socialization, finances, support system, habits, spiritual needs, how they spend their time, who is worried about them?)

PHYSICAL STATUS**:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Joint or Muscle group (HANDS, UE, NECK, TRUNK, LE)** | **Muscle functions: tone, activity tolerance and strength measured as**  0 No muscle activation  1 Trace muscle activation  2 Muscle activation with gravity eliminated  3 Muscle activation against gravity  4 Muscle activation against some resistance  5 Muscle activation against resistance | **Joint functions: stability, alignment, range, speed of movement, stiffness, joint swelling, coordination. Impairs function by:**   1. **Uses frequently for ADLS** 2. **Uses with difficulty** 3. **Impairs ADLS** 4. **Unable** | **Comments /areas of concern including PAIN** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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 |  |  |  |

**ASSESSMENT:**

**Treatment provided today and response**:

**Recommendations:**

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

**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, delete the others)

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 07/0419**