Evaluation/Reassessment Date: BRIGHTSTAR

Patient Name: | Record #:

# OCCUPATIONAL THERAPY

☐ EVALUATION
☐ FUNCTIONAL REASSESSMENT
☐ 11-13th - Visit ☐ 17-19th - Visit ☐ 30 - Day

Therapy Visit # _____ (optional per agency policy)
Combined Therapy Visit # _____ (optional per agency policy)
Reason for OT Referral:
Prior Functional Status:
Homebound ☐ Yes ☐ No If Yes, give reason:

## ASSESSMENT

**VITAL SIGNS** (per agency policy)

PULSE: ☐ Apical _____ (Reg) (Irreg) ☐ Radial _____ (Reg) (Irreg)
TEMP.: _____ RESP: _____ ☐ Actual ☐ Stated

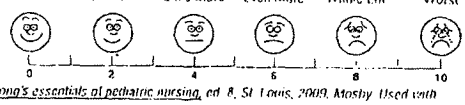
Height _____ Weight _____

| B/P | Lying | Sitting | Standing |
|---|---|---|---|
| L | | | |
| R | | | |

**PAIN** Frequency of Pain interfering with patient's activity or movement:

☐ 0 - Patient has no pain
☐ 1 - Patient has pain that does not interfere with activity or movement
☐ 2 - Less often than daily
☐ 3 - Daily, but not constantly
☐ 4 - All the time

WONG-BAKER FACES[1] PAIN RATING SCALE — Intensity: No Hurt; Hurts Little Bit; Hurts Little More; Hurts Even More; Hurts Whole Lot; Hurts Worst




[1] From Hockenberry MJ, Wilson D: Wong's essentials of pediatric nursing, ed 8, St Louis, 2009, Mosby. Used with permission. Copyright Mosby.

**PAIN PROFILE**
Primary site: _____
Onset date: _____
Pain precipitated by: _____
Pain site assessment: _____
Current pain management & effectiveness: _____
Pain description: ☐ Dull ☐ Sharp ☐ Other: _____
☐ Pain management teaching to patient/family *(document below)*
Patient's pain goal: _____

☐ See Additional Pain Assessment/Documentation (per agency policy)
Refer to:

Comments/Progress Towards Goals

**ADLs** ☐ No deficit

| | Independent | Req. Assistance | Dependent | | Independent | Req. Assistance | Dependent | | Independent | Req. Assistance | Dependent |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Bath or shower | | | | Get off/on commode | | | | Drive a car | | | |
| Wash face/hands | | | | Go up/down stairs | | | | Use publ. transpt. | | | |
| Shave/shampoo | | | | Feed self | | | | Write/Sign name | | | |
| Dress upper body | | | | Cook meals | | | | Open door | | | |
| Dress lower body | | | | Clean/homemaking | | | | Use telephone | | | |
| Ambulate | | | | Shop | | | | Other_____ | | | |

Comments/Progress Towards Goals

**RANGE OF MOTION/MOBILITY**

| Joint/ Segment | Movement | Range | PROM Right | PROM Left | AROM Right | AROM Left | Comments/Progress Towards Goals |
|---|---|---|---|---|---|---|---|
| Elbow | Flexion | 0-140 | | | | | |
| | Hyperextension | 0-0 | | | | | |
| Forearm | Pronation | 0-90 | | | | | |
| | Supination | 0-90 | | | | | |
| Wrist | Extension | 0-70 | | | | | |
| | Flexion | 0-70 | | | | | |
| | Radial Deviation | 0-70 | | | | | |
| | Ulnar Deviation | 0-70 | | | | | |
| Shoulder | Flexion | 0-180 | | | | | |
| | Abduction | 0-180 | | | | | |
| | Other | | | | | | |

**MUSCLE STRENGTH AGAINST GRAVITY**

Strength Scale: 4 = WNL 3 = Fair 2 = Poor 1 = Trace 0 = Absent

☐ LUE: ☐4 ☐3 ☐2 ☐1 ☐0 ☐ RUE: ☐4 ☐3 ☐2 ☐1 ☐0
☐ Left Hand: ☐4 ☐3 ☐2 ☐1 ☐0 ☐ Right Hand: ☐4 ☐3 ☐2 ☐1 ☐0

Comments/Progress Towards Goals

**COORDINATION**

Fine Motor Movements
☐ Altered: ☐ Physical Assist: ☐ Min ☐ Max ☐ Mod ☐ Contact Guard: ☐ Verbal Cues ☐ Supervision ☐ Unable to perform

Gross Motor Movements
☐ Altered: ☐ Physical Assist: ☐ Min ☐ Max ☐ Mod ☐ Contact Guard: ☐ Verbal Cues ☐ Supervision ☐ Unable to perform

Comments/Progress Towards Goals

**ENDURANCE**

☐ With assistive device ☐ Without assistive device
☐ 0 - Not troubled with breathlessness when performing ADLs
☐ 1 - Troubled by shortness of breath when performing ADLs
☐ 2 - Performs slower than other people of the same age on ADLs because of breathlessness or has to stop for frequent breaks to complete ADLs
☐ 3 - Usually too breathless when dressing/undressing or performing ADLs

Endurance Score: _____
Comments/Progress Towards Goals

**SENSORY EFFECTS ON THERAPY**

☐ Vision ☐ Medications ☐ Other: _____
☐ Vertigo ☐ Impaired Cognition (specify): _____
Comments

**EMOTIONAL STATUS/BEHAVIORS WHICH MAY IMPACT PLAN OF CARE**

☐ None ☐ Identified as _____

**HOME STRUCTURE/HOUSEHOLD BARRIERS THAT MAY IMPACT PLAN OF CARE**

☐ None ☐ Identified as _____

**EQUIPMENT/APPLIANCE/ADAPTIVE DEVICES**

☐ No appliances present at this time
Currently Present:
☐ Raised Toilet Seat ☐ Tub/Shower Chair ☐ Grab Bars ☐ Cane
☐ Wheelchair ☐ Hospital Bed ☐ Walker ☐ Reachers
☐ Wheelchair Ramp ☐ Flotation Mattress ☐ Slide Board ☐ Other: _____

Comments

Any Additional Problems Identified:



# OCCUPATIONAL THERAPY EVALUATION/ FUNCTIONAL REASSESSMENT

EVALUATION

## ADDITIONAL SERVICES INDICATED

☐ SLP ☐ MSS ☐ AIDE ☐ SN ☐ HME ☐ PT ☐ OTHER _____

## OCCUPATIONAL THERAPY ORDERS

Frequency/Duration of OT Visits: _____

| For: Assess/Perform/Instruct Pt/Cg: | A | P | I |
|---|---|---|---|
| ☐ Home safety assessment and intervention | ☐ | ☐ | ☐ |
| ☐ Evaluation and intervention for obtaining adaptive equipment or special devices to implement or enhance care and/or ADLs | ☐ | ☐ | ☐ |
| ☐ Training and management of adaptive devices/equipment | ☐ | ☐ | ☐ |
| ☐ ADL training/retraining | ☐ | ☐ | ☐ |
| ☐ Initiation of Home Safety Plan | ☐ | ☐ | ☐ |
| ☐ Evaluation and teaching/implementation of energy conserving techniques | ☐ | ☐ | ☐ |
| ☐ Financial counseling/linkage for additional resources | ☐ | ☐ | ☐ |
| ☐ Cognitive training | ☐ | ☐ | ☐ |
| ☐ Muscle re-education | ☐ | ☐ | ☐ |

| Assess/Perform/Instruct Pt/Cg: | A | P | I |
|---|---|---|---|
| ☐ Teach independent homemaking skills | ☐ | ☐ | ☐ |
| ☐ Body image training | ☐ | ☐ | ☐ |
| ☐ Dressing/Feeding Skill Training/Teaching | ☐ | ☐ | ☐ |
| ☐ Other _____ | ☐ | ☐ | ☐ |
| ☐ Other _____ | ☐ | ☐ | ☐ |

## GOALS / REHABILITATION POTENTIAL / DISCHARGE PLAN

**Goals:**

- ☐ The patient's ROM/Mobility will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Muscle Strength will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Coordination will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Endurance will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Pain will be controlled and managed at the patient's own comfort level as verbalized by the patient/caregiver within _____ period of time.
- ☐ Patient will obtain maximum level of functioning, as evidenced by _____ within _____ period of time.
- ☐ Patient will have ADLs met, as evidenced by _____ within _____ period of time.
- ☐ Patient will be in a safe physical environment, as evidenced by _____ within _____ period of time.
- ☐ Patient will have improved cognitive/functioning, as evidenced by _____ within _____ period of time.
- ☐ Patient/Caregiver will demonstrate safe use of equipment/adaptive devices, as evidenced by _____ within _____ period of time.
- ☐ Patient/Caregiver's expectations: _____
- ☐ Other: _____ within _____ period of time.
- ☐ Rehabilitation potential: _____

**SPECIFIC OCCUPATIONAL THERAPY GOALS**

**Measurable Short Term:** _____

**Measurable Long Term:** _____

Skilled Services provided this visit and patient response: _____

**OT DISCHARGE PLANS**

- ☐ Patient to be discharged when skilled care no longer needed
- ☐ Patient to be discharged to the care of: ☐ Self ☐ Caregiver
- ☐ Other (specify): _____
- ☐ Other: _____

REASSESSMENT

## VARIABLE FACTORS/CONDITIONS AFFECTING PATIENT'S RESPONSE

- ☐ Unexpected Temporary Illness
- ☐ Unexpected Family/Personal Event
- ☐ New Diagnosis
- ☐ Other (specify): _____

## EXPECTATIONS PATIENT'S CONDITION WILL IMPROVE

Is patient progressing towards goals? ☐ Yes ☐ No Is Goal attainable in a reasonable and generally predictable period of time? ☐ Yes ☐ No

Provide clinically supportable statement to explain: _____

Continue with current Plan of Care? ☐ Yes ☐ No If No, notify MD if update to POC is needed

Skilled Services provided this visit and patient response: _____

PATIENT NAME

Patient Signature/Date (optional per agency policy):

SPL's Signature/Date:

Time In ☐ AM ☐ PM

Time Out ☐ AM ☐ PM

Physician's Signature/Date (optional per agency policy):

CHECK ONE: ☐ G0152-OT ☐ G0160-OT Maintenance