OCCUPATIONAL THERAPY EVALUATION

DATE OF SERVICE ___/___/___

OBJECTIVE DATA TESTS AND SCALES PRINTED ON REVERSE.

TIME IN_____ OUT_____

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) _____

TYPE OF EVALUATION
☐ Initial ☐ Interim ☐ Final
SOC DATE ___/___/___
(If Initial Evaluation, complete Occupational Therapy Care Plan, form 3594/3TP)

ORDERS FOR EVALUATION ONLY? ☐ Yes ☐ No If no, orders are _____

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEM _____ ONSET ___/___/___
MEDICAL PRECAUTIONS _____
PRIOR LEVEL OF FUNCTION/WORK HISTORY _____
LIVING SITUATION/SUPPORT SYSTEM _____
HOME ENVIRONMENT _____
PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED _____

SENSORY/PERCEPTUAL MOTOR SKILLS

KEY: A-Absent I-Intact IM-Impaired U-Unable to test

Area	Sharp/Dull		Light/Firm Touch		Proprioception	
	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT
Distal UE						
Proximal UE						
Trunk						
Stereognosis						
Other						

VISUAL TRACKING _____
R/L DISCRIMINATION _____
MOTOR PLANNING PRAXIS _____
Do sensory/perceptual impairments affect safety? ☐ Yes ☐ No
If yes, recommendations _____
COMMENTS/OTHER IMPAIRMENTS NOTED _____

MUSCLE STRENGTH/FUNCTIONAL ROM EVALUATION

Area	Strength		Action	ROM	
	RIGHT	LEFT		RIGHT	LEFT
Shoulder			Flex/Extend		
			Abd./Add.		
			Int. rot./Ext. rot.		
Elbow			Flex/Extend		
Forearm			Sup./Pron.		
Wrist			Flex/Extend		
Fingers (Grip)			Flex/Extend		
Thumb			Abduction		
Cervical Spine			Flex/Extend		
			Rotation		
TOTAL SCORE			TOTAL SCORE		

DESCRIPTION/MEASUREMENT OF PROBLEM: ☐ Spasticity _____
☐ Subluxation _____ ☐ Flaccidity _____
☐ Joint Limitations _____ ☐ Contractures _____
☐ Other (specify) _____

MOTOR COMPONENTS (Circle appropriate response.)

KEY: I-Intact IM-Impaired F-Functional NF-Nonfunctional

FINE MOTOR COORDINATION: R - I/IM L - I/IM
HAND STRENGTH: R - F/NF L - F/NF PINCH: R - F/NF L - F/NF
PRIOR TO INJURY: Right / Left handed
ORTHOTIC DEVICE REQUIRED? ☐ No ☐ Yes, specify _____

FUNCTIONAL INDEPENDENCE/BALANCE EVALUATION

	Task	Assist Score	Total Score	Assistive Devices/Comments
BED MOBIL.	Roll/Turn			
	Sit/Supine			
	Sit/Stand			
TRANSFERS	Bed/Wheelchair			
	Toilet			
	Transfer technique			
	☐ Appears functional			
	☐ Add'l training required			
BALANCE	Dynamic sitting			
	Trunk control			
	Standing			

PSYCHOSOCIAL WELL-BEING

INITIATION OF ACTIVITY: ☐ Intact ☐ Impaired
COPING SKILLS: ☐ Evaluate further ☐ Intact ☐ Impaired
SELF-CONTROL: ☐ Intact ☐ Impaired
Patient/client recognizes/acknowledges physical limitations? ☐ Yes ☐ No
COMMENTS: _____

SELF-CARE SKILLS

FEEDING
Lip closure/Drooling ☐ Intact ☐ Impaired
Ability to swallow ☐ Evaluate further ☐ Intact ☐ Impaired
Ability to bring food/drink to mouth ☐ Intact ☐ Impaired
Use of utensils: _____

	Task	Assist Score	Total Score	Comments/Equipment Recommended
GROOMING	Comb hair			For testing patient/client
	Shave			☐ Standing
	Oral hygiene			☐ Sitting, surface _____
	Bath (type)			
DRESSING	UE			
	LE			
	UE/LE fasteners			
TOILET	Clothing management			
	Toilet hygiene			

COGNITIVE STATUS/COMPREHENSION (Circle or ✓ appropriate response.) I-Intact IM-Impaired T/P-To be tested/pursued

ABILITY TO EXPRESS NEEDS _____
ATTENTION SPAN _____
ORIENTED: ☐ Person ☐ Place ☐ Time

MEMORY: Short term - I IM T/P Visual - I IM T/P
Long term - I IM T/P Auditory - I IM T/P
SAFETY AWARENESS - I IM T/P JUDGMENT - I IM T/P

Complete TIME OUT (above) prior to signing here →
THERAPIST SIGNATURE/TITLE _____ DATE ___/___/___

PART 1 — Clinical Record PART 2 — Therapist PART 3 — Care Coordination

PATIENT/CLIENT NAME — Last, First, Middle Initial | ID#

OCCUPATIONAL THERAPY CARE PLAN

SOC DATE ___/___/___

DIAGNOSIS _____ ONSET ___/___/___

PROBLEM(S) _____

PATIENT/CLIENT DESIRED OUTCOMES	SHORT TERM OUTCOMES Time Frame	LONG TERM OUTCOMES Time Frame

PLAN OF CARE (Mark all applicable with an "X".)

☐ Evaluation (D1)	☐ Neuro-developmental training (D7)	☐ Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
☐ Establish rehab. program	☐ Sensory treatment (D8)	
☐ Establish home exercise program	☐ Orthotics/Splinting (D9)	☐ Other:
☐ Copy given to patient/client	☐ Adaptive equipment (fabrication and training) (D10)	
☐ Copy attached to chart	☐ Teach alternative bathing skills (unable to use tub/shower safely)	
☐ Patient/Client/Family education	☐ Retraining of cognitive, feeding and perceptual skills	
☐ Independent living/ADL training (D2)	☐ Body image training	
☐ Muscle re-education (D3)		
☐ Perceptual motor training (D5)		
☐ Fine motor coordination (D6)		

MODALITIES _____ REHAB POTENTIAL ☐ Good ☐ Fair ☐ Poor

FREQUENCY AND DURATION _____

EQUIPMENT RECOMMENDATIONS _____

SAFETY ISSUES/INSTRUCTION/EDUCATION _____

COMMENTS/ADDITIONAL INFORMATION _____

PATIENT/CLIENT/CAREGIVER RESPONSE TO PLAN OF CARE _____

DISCHARGE DISCUSSED WITH: ☐ Patient/Client/Family ☐ Care Manager ☐ Physician ☐ Other (specify)_____

CARE COORDINATION: ☐ Physician ☐ PT ☐ OT ☐ ST ☐ SS ☐ SN ☐ Other (specify)_____

APPROXIMATE NEXT VISIT DATE ___/___/___

PLAN FOR NEXT VISIT _____

PLAN DEVELOPED BY (signature/title/date) _____ ___/___/___

CARE PLAN REVIEW

DATE	REVIEWED/REVISED BY (signature/title)	COMMENTS

PART 1 — Clinical Record PART 2 - Therapist PART 3 - Care Coordination

PATIENT/CLIENT NAME — Last, First, Middle Initial	ID#

