Home Care Professionals

OCCUPATIONAL THERAPY EVALUATION

OBJECTIVE DATA TESTS AND SCALES PRINTED ON REVERSE.

DATE OF SERVICE ____/____/____

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)_____

SOC DATE____/____/____
(If Initial Evaluation, complete Occupational Therapy Care Plan)

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEM_____

ONSET____/____/____

MEDICAL PRECAUTIONS_____

PRIOR LEVEL OF FUNCTION/WORK HISTORY_____

DESCRIBE PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED_____

FALL RISK:_____

LIVING SITUATION/SUPPORT SYSTEM_____

ENVIRONMENTAL BARRIERS_____

PAIN (describe)_____ Impact on therapy care plan? ☐ Yes ☐ No

SENSORY/PERCEPTUAL MOTOR SKILLS

Area	Sharp/Dull		Light/Firm Touch		Proprioception		VISUAL TRACKING:
	Right	Left	Right	Left	Right	Left	R/L DISCRIMINATION:
							MOTOR PLANNING PRAXIS:
							Do sensory/perceptual impairments affect safety? ☐ Yes ☐ No
							If Yes, recommendations:
							COMMENTS:

COGNITIVE STATUS/COMPREHENSION

Area	I	MIN	MOD	S	U
MEMORY: Short term					
Long term					
SAFETY AWARENESS					
JUDGMENT					
Visual Comprehension					
Auditory Comprehension					

ABILITY TO EXPRESS NEEDS
ATTENTION SPAN
ORIENTED: ☐ Person ☐ Place ☐ Time ☐ Reason for Therapy

PSYCHOSOCIAL WELL-BEING

INITIATION OF ACTIVITY
COPING SKILLS ☐ Evaluate Further
SELF-CONTROL

MOTOR COMPONENTS (Enter Appropriate Response)

	I	MIN	MOD	S	U		I	MIN	MOD	S	U
FINE MOTOR COORDINATION (R)						GROSS MOTOR COORDINATION (R)					
FINE MOTOR COORDINATION (L)						GROSS MOTOR COORDINATION (L)					

PRIOR TO INJURY: ☐ Right Handed ☐ Left Handed ORTHOSIS: ☐ Used ☐ Needed (Specify):

MUSCLE STRENGTH/FUNCTIONAL ROM EVALUATION (Enter Appropriate Response)

PROBLEM AREA	STRENGTH		ROM		ROM TYPE			TONICITY		OTHER DESCRIPTIONS
	Right	Left	Right	Left	PT's	AA	A	Hyper	Hypo	

COMMENTS: _____

PATIENT NAME - Last, First, Middle Initial | ID#

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TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
FUNCTIONAL MOBILITY/BALANCE EVALUATION					
BED MOBILITY			DYNAMIC SITTING BALANCE		
BED/WHEELCHAIR TRANSFER			STATIC SITTING BALANCE		
TOILET TRANSFER			STATIC STANDING BALANCE		
TUB/SHOWER TRANSFER			DYNAMIC STANDING BALANCE		
SELF CARE SKILLS					
FEEDING			TOILETING		
SWALLOWING			BATHING		
FOOD TO MOUTH			UE DRESSING		
ORAL HYGIENE			LE DRESSING		
GROOMING			MANIPULATION OF FASTENERS		
INSTRUMENTAL ADL'S					
LIGHT HOUSEKEEPING			USE OF TELEPHONE		
LIGHT MEAL PREPARATION			MONEY MANAGEMENT		
CLOTHING CARE			MEDICATION MANAGEMENT		

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance.
4	Good strength - against gravity with some resistance.
3	Fair strength - against gravity - no resistance - safety compromise.
2	Poor strength - unable to move against gravity.
1	Trace strength - slight muscle contraction - no motion.
0	Zero - no active muscle contraction.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	100% active functional motion.
4	75% active functional motion.
3	50% active functional motion.
2	25% active functional motion.
1	Less than 25%.

FUNCTIONAL INDEPENDENCE SCALE (BED MOBILITY, TRANSFERS, BALANCE, W/C SKILLS)

GRADE	DESCRIPTION	GRADE	DESCRIPTION
5	Independent - physically able and independent.	2	Minimum assist (Min A) - 75% patient/client effort.
4	Verbal cue (VC) only needed.	1	Maximum assist (Max A) - 25% - 50% patient/client effort.
3	Stand-by assist (SBA) - 100% patient/client effort.	0	Totally dependent - total care/support.

SUMMARY

☐ OT Evaluation only. No further indications for service.

☐ Orders for OT evaluation only. Needs additional services, see OT Care Plan.

☐ Need to obtain verbal orders.

☐ Complete orders for OT services with specific treatments, frequency and duration. See OT Care Plan and/or 485.

Instruction provided: ☐ Safety ☐ Exercise ☐ Other (describe) _____

Need equipment (describe) _____

DISCHARGE DISCUSSED WITH: ☐ Patient/Family

☐ Care Manager ☐ Physician ☐ Other (specify)_____

BILLABLE SUPPLIES RECORDED? ☐ N/A ☐ Yes (specify)_____

_____

CARE COORDINATION: ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW

☐ Aide ☐ Other (specify) _____

APPROXIMATE NEXT VISIT DATE_____/_____/_____

PLAN FOR NEXT VISIT_____

_____

_____

_____

_____

PATIENT SIGNATURE (if applicable): _____

Time In _____

THERAPIST SIGNATURE/TITLE_____ DATE_____/_____/_____ Time Out_____

Home Care Professionals

OCCUPATIONAL THERAPY CARE PLAN

SOC DATE_____/_____/_____

DIAGNOSIS/REASON FOR OT: _____ ONSET_____/_____/_____

FREQUENCY AND DURATION: _____

❑ Physician orders obtained.

❑ Physician orders needed. Follow organization procedure for obtaining verbal orders and completing the 485/POC or submitting supplemental orders for physician signature.

OCCUPATIONAL THERAPY INTERVENTIONS — Locator #21

❑ Evaluation	❑ Neuro-developmental training	❑ Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
❑ Establish home exercise program ❑ Copy given to patient ❑ Copy attached to chart	❑ Sensory treatment	❑ Teach fall safety
❑ Patient/Family education	❑ Orthotics/Splinting	❑ Pulse oximetry PRN
❑ Independent living/ADL training	❑ Adaptive equipment (fabrication and training)	❑ Other:
❑ Muscle re-education	❑ Teach alternative bathing skills (unable to use tub/shower safely)	
❑ Perceptual motor training	❑ Retraining of cognitive, feeding and perceptual skills	
❑ Fine motor coordination		

OUTCOMES — Locator #22

Note: Each modality specify location, frequency, duration and amount.

PATIENT DESIRED	SHORT TERM — Time Frame	LONG TERM — Time Frame

Equipment needed: _____

Patient/Caregiver aware and agreeable to POC: ❑ Yes ❑ No (explain)_____

GOALS: OCCUPATIONAL THERAPY — Locator #22

❑ Demonstrates ability to follow home exercise program by _____ (date).

❑ Demonstrates outcomes met by _____ (date).

❑ Other (specify) _____ by _____ (date).

REHAB POTENTIAL: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

DISCHARGE PLAN: ❑ When goals met ❑ Other (specify) _____

Plan developed by:_____ Date_____

Professional signature/title

Occupational Therapy Care Plan and Physician Orders

NOTE: To be used ONLY For Supplemental Orders to Plan of Care/485 for Therapy Services.

When patient under hospice POC, the IDT determines changes to the POC with the medical director and/or attending physician.

Recommended Plan, Outcomes, Frequency & Duration as above.

Verbal orders from physician by: _____ Date_____

Professional signature/title

Physician signature: _____ Date_____

Please sign and return promptly

Original to Physician — Copy to Clinical Record (until signed original returned)

PATIENT NAME – Last, First, Middle Initial	ID#