0001204

OCCUPATIONAL THERAPY EVALUATION

❑ Initial Assessment
❑ Resumption of Care

Patient's Name	SOC Date	Certification Period From: To:	Medical Record Number
Address City State Zip			Phone Number
Allergies	Date of Birth		Sex
Nutritional Requirement	Precautions		

Home bound: ❑Yes ❑No
Reasons:
❑ Needs assistance for all activities _____
❑ Residual weakness _____
❑ Requires Maximum assistance _____
❑ Taxing effort to leave home _____
❑ Confusion _____
❑ Unsafe to go out of home unassisted _____
❑ Severe SOB. SOB upon exertion _____
❑ Other _____

ICD-9-CM Principal Diagnosis Date

Rehab Diagnosis Date

ICD-9-CM Surgical Procedures Date

Prior Level of Function:

Past Medical History

DME and Supplies

Activities Permitted
❑ Complete bedrest ❑ Wheelchair
❑ Up as tolerated ❑ Walker
❑ Crutches ❑ No restriction
❑ Cane ❑ Other: _____
❑ Splints/Braces/Prosthesis

Current Living Environment/Caregiver Support:

Cognition
❑ Short-term memory _____ ❑ Insight/judgement _____ ❑ Forgetful
❑ Long-term memory _____ ❑ Sequencing _____ ❑ Agitated
❑ Follows _____ step commands ❑ Disoriented to _____
❑ Safety awareness _____ ❑ Other: _____

VITAL SIGNS: ☐ Rest ☐ with activity ☐ post activity
Temperature: _____ Pulse: _____ Respirations: _____ BP: _____/_____
Pulse oximetry _____ with alternate vitals being taken

Environmental Barriers/Risks:

ROM/STRENGTH:
Upper Extremities:

Lower Extremities:

PAIN:
Location: _____ Intensity: _____ Duration: _____
Onset: _____ Current pain regime: _____
Is pain regime effective: ☐Yes ☐No (If no, describe interventions)
Description of pain/comments: _____

Coordination:

Fine:

Gross:

Sensation:

Auditory/Visual Function:

Neuromuscular/Tone:

Posture:

Integumentary:

Edema:

MEDICAL RECORD

0001204

OCCUPATIONAL THERAPY EVALUATION

Patient's Name	Medical Record Number

Eating:

Grooming:

Upper Body Dressing:

Lower Body Dressing:

Bathing:

Toileting:

Transfers:

Planning/Preparing Meals:

Ability to Use Phone:

Homemaking Tasks:

Balance:

Sit:

Stand:

Activity Tolerance:

SKILLED NEED/REASON FOR INTERVENTION

EDUCATION

PATIENT/CAREGIVER EDUCATION COMPLETED:	PATIENT/CAREGIVER RESPONSE:

TIME IN	❑ AM ❑ PM	TIME OUT	❑ AM ❑ PM

SIGNATURE/CREDENTIALS AND DATE