RHC™
Recovery Home Care

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

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
ENVIRONMENTAL BARRIERS
PERTINENT MEDICAL/ SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED
PAIN (describe) Impact on therapy care plan? ☐ Yes ☐ No

KEY: I - Intact, MIN - Minimally Impaired, MOD - Moderately Impaired, S - Severely Impaired, U - Untested/Unable to Test

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	ABILITY TO EXPRESS NEEDS
MEMORY: Short term						ATTENTION SPAN
Long term						ORIENTED: ☐ Person ☐ Place ☐ Time ☐ Reason for Therapy
SAFETY AWARENESS						PSYCHOSOCIAL WELL-BEING
JUDGMENT						INITIATION OF ACTIVITY
Visual Comprehension						COPING SKILLS ☐ Evaluate Further
Auditory Comprehension						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	P	AA	A	Hyper	Hypo	

COMMENTS

PART 1 - Clinical Record

PATIENT/CLIENT NAME - Last, First, Middle Initial

PART 2 - Therapist

ID#

OCCUPATIONAL THERAPY EVALUATION

☐ Continued on Reverse

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		

PATIENT GOALS:

PATIENT SIGNATURE VERIFYING VISIT:

Complete TIME OUT (on front) prior to signing here	**THERAPIST SIGNATURE/TITLE** DATE _____/_____/_____

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 musde 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, SELF-CARE SKILLS AND INSTRUMENTAL ADL SCALE

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

BALANCE SCALE (sitting - standing)

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

AVERAGE RANGES OF JOINT MOTION (ROM) SCALE

AREA	ACTION/MOVEMENT			
Shoulder	Flex 158°		Extend	55 °
	Abd.	170°	Add.	50°
	Int. rot.	70°	Ext. rot.	90°
Elbow	Flex 145°		Ext.	0°
Forearm	Sup. 85°		Pron.	70°
Wrist	Flex. 73°		Ext.	70°
Fingers	Flex all 90°		Ext.	0°
Thumb	Abduction 50%			
Cervical	Flex 35°		Ext.	35°
Spine	Rotation	45°		

RHC™
Recovery Home Care

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

FREQUENCY _____ **REHAB POTENTIAL** ☐ Good ☐ Fair ☐ Poor

MODALITIES _____

EQUIPMENT RECOMMENDATIONS _____

SAFETY ISSUES/INSTRUCTION/EDUCATION _____

COMMENTS/ADDITIONAL INFORMATION _____

PATIENT/CLIENT/CAREGIVER RESPONSE TO PLAN OF CARE _____

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

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 – Patient's Residence**

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