SOUTHEAST HOMECARE CORPORATION

PATIENT NAME: _____ D/O/B _____ EVAL DATE: _____

HOMEBOUND STATUS

[ ]	POOR COORDINATION	[ ]	LIMITED MOBILITY	[ ]	RLA (R) (L) AKA
[ ]	LEGALLY BLIND	[ ]	RLH (R) (L) HEMIPARESIS	[ ]	RLB (R) (L) BKA
[ ]	POOR BALANCE	[ ]	POOR ENDURANCE	[ ]	GENERALIZED WEAKNESS
[ ]	INADEQUATE RESPIR. FUNCT	[ ]	REQUIRES ASSIST OF	[ ]	VERTIGO
[ ]	WHEELCHAIR BOUND		1 PERSON TO LEAVE HOME	[ ]	MENTAL CONFUSION
[ ]	S.O.B. ON EXERTION	[ ]	PARAPLEGIA	[ ]	PAIN (R)
[ ]	POOR VISION	[ ]	QUADRIPLEGIA	[ ]	PAIN (L)
[ ]	CHEST PAIN ON EXERTION	[ ]	TRANSFERS ONLY	[ ]	UNSTEADY GAIT
[ ]	HARD OF HEARING	[ ]	PAIN	[ ]	OTHER