SOUTHEAST HOMECARE CORP

THERAPY EVALUATION

PATIENT NAME | PT. # | H.I. #

DIAGNOSIS/DATE ONSET:

REFERRED TO: (Circle) RN MSW ST OT HHA

LEFT			PART		RIGHT		
SPAS					SPAS		
SYN	STR	ROM		ROM	STR	SYN	
			SCAP elev.				
			Depress				
			Protract				
			Retract				
			SH flex				
			Ext				
			Abd				
			Add				
			I. Rot				
			E. Rot				
			ELBOW Flex				
			Ext				
			WRITS flex				
			Ext				
			Sup				
			Pron				
			HIP flex				
			Ext				
			Abd				
			Add				
			I. Rot				
			E. Rot				
			KNEE flex				
			Ext				
			ANKLE				
			Doral-Flex				
			Pl. Flex				
			Inver				
			Ever				
			CERV flex				
			Ext				
			Rot				
			TRUNK flex				
			Ext				
			Rot				

LIMITATIONS OF HAND AND FOOT:

NEUROLOGICAL ASSESSMENT

Pain

Reflexes

Other

Dresses self

Feeds self

Bathes self

Sitting balance

Static standing balance

Dynamic standing balance

Transfers:

Bed Mobility:

Gets in and out of tub/shower

GAIT EVALUATION

Climb Steps

Architectural Barriers

Clinical Findings Summary:

Prior level:

DME present/needed

Obstacles:

Lighting:

Placement of furniture:

Homebound Status:

Lives with:

S.O./Pt. UNDERSTANDING

EMERGENCY PLAN:

P.T. GOALS

REHAB POTENTIAL TO ACHIEVE GOALS:

REASON:

ATMENT:

T: