Total Nursing Services, Inc
5951 NW 173 DR,
Suite # 11
Miami, FL 33015

Evaluation/Reassessment Date:

Patient Name: Record #:

OCCUPATIONAL THERAPY

☐ EVALUATION

☐ FUNCTIONAL REASSESSMENT

☐ 11-13th - Visit ☐ 17-19th - Visit ☐ 30 - Day

Therapy Visit # _____ (optional per agency policy)

Combined Therapy Visit # _____ (optional per agency policy)

Reason for OT Referral:

Prior Functional Status:

Homebound ☐ Yes ☐ No If Yes, give reason:

ASSESSMENT

VITAL SIGNS
(per agency policy)

PULSE: ☐ Apical _____ (Reg) (Irreg)
☐ Radial _____ (Reg) (Irreg)
TEMP.:_____ RESP:_____ ☐ Actual ☐ Stated

Height _____ Weight _____

B/P Lying Sitting Standing
L _____ _____ _____
R _____ _____ _____

PAIN

Frequency of Pain interfering with patient's activity or movement:

☐ 0 - Patient has no pain
☐ 1 - Patient has pain that does not interfere with activity or movement
☐ 2 - Less often than daily
☐ 3 - Daily, but not constantly
☐ 4 - All the time

PAIN PROFILE

Primary site: _____

Onset date: _____

☐ See Additional Pain Assessment/Documentation (per agency policy)
Refer to:

Pain precipitated by: _____

Pain site assessment: _____

Current pain management & effectiveness: _____

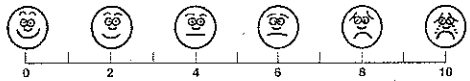
Pain description: ☐ Dull ☐ Sharp ☐ Other: _____

☐ Pain management teaching to patient/family *(document below)*

Patient's pain goal: _____

WONG-BAKER FACES[1] PAIN RATING SCALE

Intensity: No Hurt | Hurts Little Bit | Hurts Little More | Hurts Even More | Hurts Whole Lot | Hurts Worst



[1] *From Hockenberry MJ, Wilson D: Wong's essentials of pediatric nursing, ed. 8, St. Louis, 2009, Mosby. Used with permission. Copyright Mosby.*

Comments/Progress Towards Goals

ADLs

☐ No deficit

	Independent	Req. Assistance	Dependent		Independent	Req. Assistance	Dependent		Independent	Req. Assistance	Dependent
Bath or shower				Get off/on commode				Drive a car			
Wash face/hands				Go up/down stairs				Use publ. transpt.			
Shave/shampoo				Feed self				Write/Sign name			
Dress upper body				Cook meals				Open door			
Dress lower body				Clean/homemaking				Use telephone			
Ambulate				Shop				Other_____			

Comments/Progress Towards Goals

RANGE OF MOTION/MOBILITY

Joint/ Segment	Movement	Range	PROM Right	PROM Left	AROM Right	AROM Left	Comments/Progress Towards Goals
Elbow	Flexion	0-140					
	Hyperextension	0-0					
Forearm	Pronation	0-90					
	Supination	0-90					
Wrist	Extension	0-70					
	Flexion	0-70					
	Radial Deviation	0-70					
	Ulnar Deviation	0-70					
Shoulder	Flexion	0-180					
	Abduction	0-180					
	Other						

ENDURANCE

☐ With assistive device ☐ Without assistive device

☐ 0 - Not troubled with breathlessness when performing ADLs
☐ 1 - Troubled by shortness of breath when performing ADLs
☐ 2 - Performs slower than other people of the same age on ADLs because of breathlessness or has to stop for frequent breaks to complete ADLs
☐ 3 - Usually too breathless when dressing/undressing or performing ADLs

Endurance Score: _____

Comments/Progress Towards Goals

EQUIPMENT/APPLIANCE/ADAPTIVE DEVICES

☐ No appliances present at this time

Currently Present:

☐ Raised Toilet Seat ☐ Tub/Shower Chair ☐ Grab Bars ☐ Cane
☐ Wheelchair ☐ Hospital Bed ☐ Walker ☐ Reachers
☐ Wheelchair Ramp ☐ Flotation Mattress ☐ Slide Board ☐ Other: _____

Comments

MUSCLE STRENGTH AGAINST GRAVITY

Strength Scale: 4 = WNL 3 = Fair 2 = Poor 1 = Trace 0 = Absent

☐ LUE: ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0 ☐ RUE: ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0
☐ Left Hand: ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0 ☐ Right Hand: ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

Comments/Progress Towards Goals

COORDINATION

Fine Motor Movements

☐ Altered: ☐ Physical Assist: ☐ Min ☐ Max ☐ Mod ☐ Contact Guard: ☐ Verbal Cues ☐ Supervision ☐ Unable to perform

Gross Motor Movements

☐ Altered: ☐ Physical Assist: ☐ Min ☐ Max ☐ Mod ☐ Contact Guard: ☐ Verbal Cues ☐ Supervision ☐ Unable to perform

Comments/Progress Towards Goals

SENSORY EFFECTS ON THERAPY

☐ Vision ☐ Medications ☐ Other: _____
☐ Vertigo ☐ Impaired Cognition (specify): _____

Comments

EMOTIONAL STATUS/BEHAVIORS WHICH MAY IMPACT PLAN OF CARE

☐ None ☐ Identified as _____

HOME STRUCTURE/HOUSEHOLD BARRIERS THAT MAY IMPACT PLAN OF CARE

☐ None ☐ Identified as _____

Any Additional Problems Identified: _____

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OCCUPATIONAL THERAPY EVALUATION/ FUNCTIONAL REASSESSMENT

ADDITIONAL SERVICES INDICATED

☐ SLP ☐ MSS ☐ AIDE ☐ SN ☐ HME ☐ PT ☐ OTHER _____

OCCUPATIONAL THERAPY ORDERS

Frequency/Duration of OT Visits: _____

EVALUATION

For: Assess/Perform/Instruct Pt/Cg:	A	P	I
☐ Home safety assessment and intervention	☐	☐	☐
☐ Evaluation and intervention for obtaining adaptive equipment or special devices to implement or enhance care and/or ADLs	☐	☐	☐
☐ Training and management of adaptive devices/equipment	☐	☐	☐
☐ ADL training/retraining	☐	☐	☐
☐ Initiation of Home Safety Plan	☐	☐	☐
☐ Evaluation and teaching/implementation of energy conserving techniques	☐	☐	☐
☐ Financial counseling/linkage for additional resources	☐	☐	☐
☐ Cognitive training	☐	☐	☐
☐ Muscle re-education	☐	☐	☐

Assess/Perform/Instruct Pt/Cg:	A	P	I
☐ Teach independent homemaking skills	☐	☐	☐
☐ Body image training	☐	☐	☐
☐ Dressing/Feeding Skill Training/Teaching	☐	☐	☐
☐ Other _____	☐	☐	☐
_____			
_____			
☐ Other _____	☐	☐	☐
_____			
_____			

GOALS / REHABILITATION POTENTIAL / DISCHARGE PLAN

Goals:

- ☐ The patient's ROM/Mobility will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Muscle Strength will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Coordination will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Endurance will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Pain will be controlled and managed at the patient's own comfort level as verbalized by the patient/caregiver within _____ period of time.
- ☐ Patient will obtain maximum level of functioning, as evidenced by _____ within _____ period of time.
- ☐ Patient will have ADLs met, as evidenced by _____ within _____ period of time.
- ☐ Patient will be in a safe physical environment, as evidenced by _____ within _____ period of time.
- ☐ Patient will have improved cognitive/functioning, as evidenced by _____ within _____ period of time.
- ☐ Patient/Caregiver will demonstrate safe use of equipment/adaptive devices, as evidenced by _____ within _____ period of time.
- ☐ Patient/Caregiver's expectations: _____
- ☐ Other: _____ within _____ period of time.
- ☐ Rehabilitation potential: _____

SPECIFIC OCCUPATIONAL THERAPY GOALS

Measurable Short Term: _____

Measurable Long Term: _____

Skilled Services provided this visit and patient response: _____

OT DISCHARGE PLANS

☐ Patient to be discharged when skilled care no longer needed ☐ Other (specify): _____

☐ Patient to be discharged to the care of: ☐ Self ☐ Caregiver ☐ Other: _____

REASSESSMENT

VARIABLE FACTORS/CONDITIONS AFFECTING PATIENT'S RESPONSE

☐ Unexpected Temporary Illness ☐ New Diagnosis

☐ Unexpected Family/Personal Event ☐ Other (specify): _____

EXPECTATIONS PATIENT'S CONDITION WILL IMPROVE

Is patient progressing towards goals? ☐ Yes ☐ No Is Goal attainable in a reasonable and generally predictable period of time? ☐ Yes ☐ No

Provide clinically supportable statement to explain: _____

Continue with current Plan of Care? ☐ Yes ☐ No If No, notify MD if update to POC is needed

Skilled Services provided this visit and patient response: _____

PATIENT NAME	Patient Signature/Date (optional per agency policy):	
SPL's Signature/Date:	Time In ☐ AM ☐ PM	Physician's Signature/Date (optional per agency policy):
	Time Out ☐ AM ☐ PM	

CHECK ONE: ☐ G0152-OT ☐ G0160-OT Maintenance

TNS
TOTAL NURSING SERVICES, INC.

Weekly Visit/Time Records

Employee ID: _____ Employee Name: _____

❑ RN ❑ LPN ❑ HHA ❑ PT ❑ PTA ❑ OT ❑ SP ❑ MSW

Patient Name: _____ Patient ID: _____

PLEASE SIGN FOR ONLY ONE VISIT A TIME

POR FAVOR SOLO FIRME POR UNA VISITA A LA VEZ

DAY/DIA	DATE FECHA	VISIT CODE	N/C CODE	TIME IN ENTRADA		TIME OUT SALIDA		PATIENT/CAREGIVER SIGNATURE FIRMA DE PACIENTE/CUIDADOR
SUNDAY					❑ AM ❑ PM		❑ AM ❑ PM	
MONDAY					❑ AM ❑ PM		❑ AM ❑ PM	
TUESDAY					❑ AM ❑ PM		❑ AM ❑ PM	
WEDNESDAY					❑ AM ❑ PM		❑ AM ❑ PM	
THURSDAY					❑ AM ❑ PM		❑ AM ❑ PM	
FRIDAY					❑ AM ❑ PM		❑ AM ❑ PM	
SATURDAY					❑ AM ❑ PM		❑ AM ❑ PM	

IF PATIENT IS UNABLE TO SIGN PLEASE PROVIDE NAME AND RELATIONSHIP OF CAREGIVER

SI EL PACIENTE NO PUEDE FIRMAR SE NECESITA EL NOMBRE Y EL PARENTESCO DE EL CUIDADOR: _____

DAY/DIA	DATE FECHA	VISIT CODE	N/C CODE	TIME IN ENTRADA		TIME OUT SALIDA		PATIENT/CAREGIVER SIGNATURE FIRMA DE PACIENTE/CUIDADOR
SUNDAY					❑ AM ❑ PM		❑ AM ❑ PM	
MONDAY					❑ AM ❑ PM		❑ AM ❑ PM	
TUESDAY					❑ AM ❑ PM		❑ AM ❑ PM	
WEDNESDAY					❑ AM ❑ PM		❑ AM ❑ PM	
THURSDAY					❑ AM ❑ PM		❑ AM ❑ PM	
FRIDAY					❑ AM ❑ PM		❑ AM ❑ PM	
SATURDAY					❑ AM ❑ PM		❑ AM ❑ PM	

VISIT CODES:
P-PATIENT VISIT (ALL SKILLS)
X-PSYCH SN VISIT
HT-HIGH TECH INFUSION THERAPY VISIT
S/U-SIGN UP VISIT
ROC-RESUMPTION OF CARE
R/C-RE-CERTIFICATION VISIT
D/C-DISCHARGE VISIT
S/V-SUPERVISORY VISIT

N/C CODES (NO CHARGE)
1-NON BILLABLE SUPERVISORY VISIT
2-SUPPLY DELIVERY
3-CHARITY VISIT