Your Company Logo

Your Company Name
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OCCUPATIONAL THERAPY EVALUATION

REASON FOR O.T. EVALUATION: _____

NAME: _____ ADM. DATE: _____

RM #: _____ ID#: _____ DOB: _____ AGE: _____

DIAGNOSIS: _____

_____

HEMIPARESIS/HEMIPLEGIA

PREVIOUS FUNCTIONAL STATUS: _____

PRECAUTIONS: _____

MENTAL STATUS: _____

UE STATUS: _____

PROM: WFL _____ LIMITATION OF MOTION: BOTH SIDES _____ RIGHT _____ LEFT

SHOULDER / ELBOW ❑ WRIST / HAND ❑ CONTRACTURES (SPECIFY): _____

MUSCLE TONE: _____ EDEMA: _____

VOLUNTARY MOV'T (AROM): NO LOSS: _____ PARTIAL LOSS: _____ TOTAL LOSS: _____

SPECIFY: _____

STRENGTH: _____

GROSS MOTOR SKILLS: _____

FINE DEXTERITY: NO LOSS: _____ LOSS: _____ SPECIFY: _____

SITTING BALANCE MDS ( ): _____

ADDITIONAL STATUS: FEEDING: _____

DRESSING: _____

GROOMING: _____

BED MOBILITY: _____

TRANSFERS: _____

STANDING BALANCE: SUPPORTED: _____ UNSUPPORTED: _____ UNABLE TO TEST: _____

PERCEPTUAL STATUS: INTACT: _____ IMPAIRED: _____ SPECIFY: _____

W/C POSITIONING: _____

DEVICES: _____

REHABILITATION POTENTIAL: _____

RESIDENT'S GOALS: _____

SHORT TERM GOALS: _____ EST. ACH DATE: _____

_____

_____

LONG TERM GOALS: _____

_____

TREATMENT PLAN: _____

_____

TYPE OF THERAPY: RESTORATIVE: _____ MAINT.: _____ TIME/WK: _____ DAYS/WK: _____

RECOMMENDATIONS: _____

_____

_____

ROM PROGRAM: FREQUENCY _____ GOAL: _____

SIGNATURE: _____ DATE: _____