REHABILITATION SCREENING REQUEST

Resident_____ Room_____ Date of Request_____

Reason for Referral (Relate to ADL Function) _____

_____

_____

_____

Indicate the resident's precipitating medical condition or event:

- ☐ CVA
- ☐ Newly Diagnosed Arthritis/Change in Arthritic condition
- ☐ Post Infectious process
- ☐ Newly Diagnosed Orthopedic Condition/Change in condition
- ☐ DVT
- ☐ Newly diagnosed Cardiac Condition/ Change in condition
- ☐ Newly Diagnosed Renal disease/Change in Renal Disease
- ☐ Newly Diagnose neurological condition/Change in neurological condition
- ☐ Parkinson's Disease/Change in Treatment of Disease
- ☐ Decrease in ADL secondary to Pain complaint
- ☐ Fall
- ☐ Other:_____
  - o OOB
  - o During Ambulation
  - o During Transfer
    - ☐ Bed
    - ☐ Toilet
    - ☐ Wheelchair
    - ☐ Other_____

Discharge Plan to what level of care:

- ☐ Private Home
- ☐ Adult Home
- ☐ Assisted Living
- ☐ Other_____

Request the following Service:

OCCUPATIONAL THERAPY	PHYSICAL THERAPY	SPEECH THERAPY
☐ Feeding screen	☐ Ambulation screen	☐ Feeding/swallowing screen
☐ Wheelchair Positioning screen	☐ Transfer screen	☐ Hearing screen
☐ ADL screen	☐ Ambulation device	☐ Speech screen
☐ Upper Extremity splint screen	☐ Lower Extremity screen	
☐ Preparation for discharge	☐ Preparation for discharge	☐ Preparation for discharge

Requested by_____ Date_____

Response from Rehabilitation Service(s)_____

_____

_____

_____

Therapist signature_____ Date_____

Physiatrist/MD Referral Yes_____ No_____

Physician signature_____ Date_____