OCCUPATIONAL THERAPY INITIAL ~~EVALUATION~~ / PLAN OF TREATMENT

Telephone 1-800-755-6684
270-365-2011
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Home Health Agency

JCAHO Accredited
Medicare / Medicaid Certified

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Time In _____ **Time Out** _____

Patient: _____ **HIC #:** _____

Physician: _____ **Date:** _____

History: The patient is a(n) y/o (fe)male referred to Occupational Therapy for evaluation and application of appropriate procedures.

Diagnosis: _____

Past Medical History: _____

_____

_____

Precautions: _____

Home Environment: _____

_____

_____

Patient's Prior Status: _____

_____

OBJECTIVE:

Dressing: UE_____ **LE**_____

Bathing: UE_____ **LE**_____

Tub Transfer: _____

Grooming: _____

Toilet Transfer: _____ **Toileting:** _____

Eating: _____

Activity Tolerance: _____

Homemaking Skills: _____

_____

_____

Architectural Barriers / Equipment Needed: _____

_____

_____

Upper Extremity Status:

R UE: _____

_____

_____

L UE: _____

_____

_____

continued

Hand Function:

FMC: R hand: _____ **L hand:** _____

Grasp Strength, Grossly: R hand: _____ **L hand:** _____

_____

Sensory:

Light Touch: R UE: _____ **L UE:** _____

Deep Touch: R UE: _____ **L UE:** _____

Hot / Cold: R UE: _____ **L UE:** _____

Pain: R UE: _____ **L UE:** _____

_____

Visual / Perceptual:

HOH: _____ **Eyeglasses:** _____

Spatial Relations: _____ **Depth Perception:** _____

_____

Cognitive Status:

Memory: Long Term: _____ **Short Term:** _____

_____

ASSESSMENT: _____

_____

_____

_____

Problem List:

1. _____
2. _____
3. _____
4. _____

Goals:

1. _____
2. _____
3. _____
4. _____

Rehabilitation Potential: Excellent_____ Good_____ Fair_____ Poor_____

PLAN: _____

_____

_____

Frequency / Duration: _____

Thank you for this referral.

_____ _____

THERAPIST SIGNATURE **DATE** **PHYSICIAN SIGNATURE** **DATE**