**Subjective:**

- **G: ASSESSED:** Bedside
- **Department:**
- **Lines/Equipment:** IV Left/Right site
- **Foley/Texas catheter:**
- **O2 at:** L/min
- **Other:**
- **Plan:** Rate (0 - 10 scale)
- **Comments:**

**MENTAL STATUS:**
- **Orientation:**
- **Place:**
- **Time:**
- **Circumstance:**
- **Level of Alertness:**
- **Alert:**
- **Lethargic:**
- **Unresponsive:**
- **Follows Commands:**
- **One Step:**
- **Two Step:**
- **General Comments:**

**VISION/PERCEPTION:**

**UPPER EXTREMITY:**
- **Dominance:**
- **Right**
- **Left**
- **Involved Extremity:**
- **Right**
- **Left**
- **Not Applicable**
- **ROM:**
- **Strength:**
- **Sensation:**
- **Coordination:**
- **Comments:**

**LOWER EXTREMITY:**
- **Mobility Device:**
- **Weight Bearing Status:**
- **NWB**
- **Touch**
- **Partial**
- **As tol**
- **Full**
- **Not Applicable**
- **Right**
- **Left**

**TRUNK/SITTING BALANCE:**

**ACTIVITIES OF DAILY LIVING:**
- **Key:**
- **I = Independent**
- **Min = Minimal Assistance**
- **Mod = Modified Independent**
- **ModA = Moderate Assistance**
- **S = Supervision**
- **Max A = Maximal Assistance**
- **Dep = Dependent**

<table>
<thead>
<tr>
<th>SELF CARE</th>
<th>PRESENT STATUS</th>
<th>COMMENTS</th>
<th>FUNCTIONAL MOBILITY /TRANSFERS</th>
<th>PRESENT STATUS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding</td>
<td></td>
<td></td>
<td>Bed Mobility</td>
<td></td>
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<tr>
<td>Grooming</td>
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<td></td>
<td>Sit to Stand</td>
<td></td>
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<tr>
<td>Bathing - Upper Body</td>
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<td>Bed to Chair</td>
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<tr>
<td>Bathing - Lower Body</td>
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<td>Toilet Transfer</td>
<td></td>
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<tr>
<td>Dressing - Upper Body</td>
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<td></td>
<td>Tub/Shower Transfer</td>
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<tr>
<td>Dressing - Lower Body</td>
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<td>Other</td>
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<tr>
<td>Toileting</td>
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**TREATMENT:**
- **Patient Instructed**
- **ADLs**
- **Transfers**
- **Adaptive Equip.**
- **THR Precautions**
- **Energy Conservation**
- **Safety Considerations In the home**
- **Other:**

<table>
<thead>
<tr>
<th>Activity tolerance</th>
<th>low</th>
<th>fair</th>
<th>good</th>
<th>normal</th>
</tr>
</thead>
</table>

**ASSESSMENT:**
- **O.T. findings include**
- **LEVEL OF UNDERSTANDING OF INSTRUCTION:**
- **poor**
- **fair**
- **good**

**Comments:**

**PLAN:**

**LEARNING NEEDS**
- **P A T I E N T / C A R E G I V E R E D U C A T I O N**
- **METHODS OF INSTRUCTION**
- **EVALUATION OF EFFECTIVENESS**

- **ADLS**
- **Functional mobility**
- **Demo**
- **verbal**
- **written**
- **Return Demo**

**SHORT TERM GOALS:**

1. Pt will
2. Pt will
3. Pt will

**LONG TERM GOALS:**

1. Pt will

- Patient / Family agrees to participate in therapy **Yes**
- Patient / Family goal(s)

**PHYSICAL THERAPY EQUIPMENT / PLANS:**

- **Plans at Discharge:**
- **Home**
- **Home with supervision**
- **Home OT**
- **Outpatient OT**
- **Subacute**
- **Comprehensive Rehab**
- **Skilled Nursing Facility**
- **Equipment Needed:**
- **No**
- **Yes**

**Signature:**

**License No.:**

**Date:**

**Time:**

**Duration:**

**Patient Identification**

**Hospital**

**OCCUPATIONAL THERAPY ASSESSMENT AND PLAN OF CARE**