OCCUPATIONAL THERAPY EVALUATION

OBJECTIVE DATA TESTS AND SCALES PRINTED ON REVERSE. **DATE OF SERVICE**_____/_____/_____

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions
❑ Other (specify)_____

SOC DATE_____/_____/_____
(If Initial Evaluation, complete Occupational Therapy Care Plan)

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEM_____
_____ **ONSET**_____/_____/_____
MEDICAL PRECAUTIONS_____
PRIOR LEVEL OF FUNCTION/WORK HISTORY_____
_____
DESCRIBE PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED_____
_____ **FALL RISK:**_____
LIVING SITUATION/SUPPORT SYSTEM_____
ENVIRONMENTAL BARRIERS_____
PAIN (describe)_____ Impact on therapy care plan? ❑ Yes ❑ No

KEY: I - Intact, MIN - Minimally Impaired, MOD - Moderately Impaired, S - Severely Impaired, U - Untested/Unable to Test

SENSORY/PERCEPTUAL MOTOR SKILLS

Area	Sharp/Dull		Light/Firm Touch		Proprioception	
	Right	Left	Right	Left	Right	Left

VISUAL TRACKING:
R/L DISCRIMINATION:
MOTOR PLANNING PRAXIS:
Do sensory/perceptual impairments affect safety? ❑ Yes ❑ No
If Yes, recommendations:
COMMENTS:

COGNITIVE STATUS/COMPREHENSION

Area	I	MIN	MOD	S	U
MEMORY: Short term					
Long term					
SAFETY AWARENESS					
JUDGMENT					
Visual Comprehension					
Auditory Comprehension					

ABILITY TO EXPRESS NEEDS
ATTENTION SPAN
ORIENTED: ❑ Person ❑ Place ❑ Time ❑ Reason for Therapy

PSYCHOSOCIAL WELL-BEING

INITIATION OF ACTIVITY
COPING SKILLS ❑ Evaluate Further
SELF-CONTROL

MOTOR COMPONENTS (Enter Appropriate Response)

	I	MIN	MOD	S	U		I	MIN	MOD	S	U
FINE MOTOR COORDINATION (R)						**GROSS MOTOR COORDINATION (R)**					
FINE MOTOR COORDINATION (L)						**GROSS MOTOR COORDINATION (L)**					

PRIOR TO INJURY: ❑ Right Handed ❑ Left Handed **ORTHOSIS:** ❑ Used ❑ Needed (Specify):

MUSCLE STRENGTH/FUNCTIONAL ROM EVALUATION (Enter Appropriate Response)

PROBLEM AREA	STRENGTH		ROM		ROM TYPE			TONICITY		OTHER DESCRIPTIONS
	Right	Left	Right	Left	P	AA	A	Hyper	Hypo	

COMMENTS: _____

PATIENT NAME – Last, First, Middle Initial | ID#

❑ Continued on Back

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
FUNCTIONAL MOBILITY/BALANCE EVALUATION					
BED MOBILITY			DYNAMIC SITTING BALANCE		
BED/WHEELCHAIR TRANSFER			STATIC SITTING BALANCE		
TOILET TRANSFER			STATIC STANDING BALANCE		
TUB/SHOWER TRANSFER			DYNAMIC STANDING BALANCE		
SELF CARE SKILLS					
FEEDING			TOILETING		
SWALLOWING			BATHING		
FOOD TO MOUTH			UE DRESSING		
ORAL HYGIENE			LE DRESSING		
GROOMING			MANIPULATION OF FASTENERS		
INSTRUMENTAL ADL'S					
LIGHT HOUSEKEEPING			USE OF TELEPHONE		
LIGHT MEAL PREPARATION			MONEY MANAGEMENT		
CLOTHING CARE			MEDICATION MANAGEMENT		

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance.
4	Good strength - against gravity with some resistance.
3	Fair strength - against gravity - no resistance - safety compromise.
2	Poor strength - unable to move against gravity.
1	Trace strength - slight muscle contraction - no motion.
0	Zero - no active muscle contraction.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	100% active functional motion.
4	75% active functional motion.
3	50% active functional motion.
2	25% active functional motion.
1	Less than 25%.

FUNCTIONAL INDEPENDENCE SCALE (BED MOBILITY, TRANSFERS, BALANCE, W/C SKILLS)

GRADE	DESCRIPTION
5	Independent - physically able and independent.
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) - 100% patient/client effort.
2	Minimum assist (Min A) - 75% patient/client effort.
1	Maximum assist (Max A) - 25% - 50% patient/client effort.
0	Totally dependent - total care/support.

SUMMARY

❑ OT Evaluation only. No further indications for service.

❑ Orders for OT evaluation only. Needs additional services, see OT Care Plan.

❑ Need to obtain verbal orders.

❑ Complete orders for OT services with specific treatments, frequency and duration. See OT Care Plan and/or 485.

Instruction provided: ❑ Safety ❑ Exercise ❑ Other (describe) _____

Need equipment (describe) _____

DISCHARGE DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify)_____

BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify)_____

CARE COORDINATION: ❑ Physician ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ Other (specify) _____

APPROXIMATE NEXT VISIT DATE_____/_____/_____

PLAN FOR NEXT VISIT_____

PATIENT SIGNATURE (if applicable):_____

THERAPIST SIGNATURE/TITLE_____ **DATE**_____/_____/_____ **Time In** _____ **Time Out**_____