OCCUPATIONAL THERAPY EVALUATION

PERMITTED MEDICAL INFORMATION

Onset Date: __ / __ / __

Primary Diagnosis:

Medical Precautions/Limitations:

Recent Change or Need for Therapy:

Pain:

Rating scale: 0 1 2 3 4 5 6 7 8 9 10

Current pain level: ___

Pain quality: ___ Pain location: ___

Frequency: Occasionally Continuous Intermittent Other

What makes pain worse? Movement Ambulation Immobility

Referral needed? Yes No Referred to:

Impacting function? Yes No (specify)

SOC DATE __ / __ / __

PERMITTED BACKGROUND INFORMATION

Prior Level of Functioning With ADLs:

Independent Needed assist Total assist

History of Falls:

Yes No If yes, date of last fall: __ / __ / __

Intervention in place? Yes No

If yes, specify:

Reported by: Patient Family Caregiver

Support System:

Lives alone Caregiver available

Limited support No caregiver available

Comment:

Environmental Barriers: Clutter Throw rugs

Adaptive equipment needed: Yes No

(type)

Other:

POC Goal Needed? Yes No

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

SENSORY/PERCEPTUAL MOTOR SKILLS

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<td>Right</td>
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<td>Yes</td>
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<td>Yes</td>
<td>No</td>
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COGNITIVE STATUS/COMPREHENSION

ORIENTED: Person Place Time Reason for Therapy

Deficit Area Impaired Intact Functional Deficit Area Impaired Intact Functional

MEMORY: Short term

Long term

Attention/Concentration

Auditory Comprehension

Visual Comprehension

Self-Control

Impacting function? Yes No (specify)

POC Goal Needed? Yes No

MOTOR COMPONENTS (Enter Appropriate Response)

Fine Motor Coordination Impaired Intact Functional Gross Motor Coordination Impaired Intact Functional

Right

Left

Right handed Left handed

Orthosis Used Needed (specify)

Impacting function? Yes No (specify)

POC Goal Needed? Yes No

PATIENT NAME – Last, First, Middle Initial

ID#
## FUNCTIONAL MOBILITY/BALANCE EVALUATION

### SELF CARE SKILLS/ADL SKILLS

<table>
<thead>
<tr>
<th>TASK</th>
<th>Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Mobility</td>
<td></td>
<td></td>
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<tr>
<td>Bed/Wheelchair Transfer</td>
<td></td>
<td></td>
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<tr>
<td>Toilet Transfer</td>
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<tr>
<td>Tub/Shower Transfer</td>
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</tbody>
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**FUNCTIONAL MOBILITY/BALANCE EVALUATION**

<table>
<thead>
<tr>
<th>TASK</th>
<th>Score</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>DYNAMIC SITTING BALANCE</td>
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<tr>
<td>STATIC SITTING BALANCE</td>
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<td></td>
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<tr>
<td>STATIC STANDING BALANCE</td>
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<td></td>
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<tr>
<td>DYNAMIC STANDING BALANCE</td>
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</tbody>
</table>

**OBJECTIVE DATA TESTS AND SCALES**

### MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>5</td>
<td>Normal functional strength - against gravity - full resistance.</td>
</tr>
<tr>
<td>4</td>
<td>Good strength - against gravity with some resistance.</td>
</tr>
<tr>
<td>3</td>
<td>Fair strength - against gravity - no resistance - safety compromise.</td>
</tr>
<tr>
<td>2</td>
<td>Poor strength - unable to move against gravity.</td>
</tr>
<tr>
<td>1</td>
<td>Trace strength - slight muscle contraction - no motion.</td>
</tr>
<tr>
<td>0</td>
<td>Zero - no active muscle contraction.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>5</td>
<td>100% active functional motion.</td>
</tr>
<tr>
<td>4</td>
<td>75% active functional motion.</td>
</tr>
<tr>
<td>3</td>
<td>50% active functional motion.</td>
</tr>
<tr>
<td>2</td>
<td>25% active functional motion.</td>
</tr>
<tr>
<td>1</td>
<td>Less than 25%.</td>
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</table>

### FUNCTIONAL INDEPENDENCE SCALE (For Balance/Mobility, Self Care/ADL Skills, IADL Skills)

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>7</td>
<td>Independent.</td>
</tr>
<tr>
<td>6</td>
<td>Modified independent - verbal cues, extra time.</td>
</tr>
<tr>
<td>5</td>
<td>Stand-by assist (SBA) - 100% effort w/supervision.</td>
</tr>
<tr>
<td>4</td>
<td>Minimal assist - 75% effort.</td>
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<tr>
<td>3</td>
<td>Moderate assist - 25-50% effort.</td>
</tr>
<tr>
<td>2</td>
<td>Maximum assist - 25% effort.</td>
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<tr>
<td>1</td>
<td>Dependent/unable to do task &lt;25% effort.</td>
</tr>
</tbody>
</table>

**INSTRUMENTAL ADL’S**

<table>
<thead>
<tr>
<th>TASK</th>
<th>Score</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Housekeeping</td>
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<tr>
<td>Meal Preparation</td>
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<td></td>
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<tr>
<td>Laundry</td>
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**IMPACTING FUNCTION?**

- Yes
- No (specify)
**SUMMARY**

Was a standardized/validated assessment used?  
- Yes  
- No  
If yes (specify assessment):  

Results:  

Need for OT evaluation only.  
- Yes  
- No  
If yes: (specify)  

Instruction/Education provided:  
- Yes  
- No  
- Safety  
- Exercise  
- Other (specify)  

Equipment recommendations: (specify)  

There are no changes to the POC based upon this assessment, at this time.  

Was a need identified or reported during this assessment in any of the following areas that requires a referral?  
- Pain  
- Injuries/Wounds  
- Psychosocial concerns  
- Self care skills  
- IADLs  
- Safety issues  
- Other:  

- Yes  
- No  
If Yes: (specify)  

Referral recommendations: (specify)  

Comments:  

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**DISCHARGE DISCUSSED WITH:**

- Patient  
- Family/Caregiver  
- Care Manager  
- Physician  
- Other:  

**CARE COORDINATION:**

- Physician  
- Nursing  
- PT  
- OT  
- ST  
- MSW  
- Aide  
- Other:  

**APPROXIMATE NEXT VISIT DATE:** / /  

**PLAN FOR VISIT:**  

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**SIGNATURES/DATES**

<table>
<thead>
<tr>
<th>Patient/Caregiver (if applicable)</th>
<th>Date</th>
<th>Therapist (signature/title)</th>
<th>Date</th>
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<tbody>
<tr>
<td>X</td>
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Complete TIME OUT (on previous page) prior to signing below.