## Therapeutic Recreation/Activity Assessment

### Personal Strengths
- Motivated
- Cooperative
- Adapts to change
- Cheerful
- Leisure interests
- Independent
- Able to make needs known
- Feels useful
- Developed coping skills
- Sense of humor
- Decisive
- Other: __________

### Social Support Systems
#### A. Primary Visitors
- Family
- Friend / Peer
- Volunteer:
  - Community
  - Facility
- Religious
- Pet
- No visitors
- Other __________

#### B. Types of Contact
- Visits
- Telephone
- Mail
- Outings
- Other __________

#### C. Helps Others
- Volunteer:
  - Community
  - Facility
  - Therapeutic Work
  - Friendly visitor
  - Activity leader
  - Other
  - No interest

### Recreation Interests/Needs
#### A. Activity Environment
- Groups:
  - Large
  - Small
  - Special Needs
- Independent (self-directed)
- One-to-one
- Community
- Own room
- Day/Activities room
- Inside facility/off unit
- Indoor
- Outdoor
- Other
- No Interest

#### B. Participation in Activities
- Active participation
- Passive participation
- Independent/Individual
- Leadership exhibited
- Encouragement needed
- No Interest

#### C. Activity Schedule Preference
- Morning
- Afternoon
- Evening
- None of these, (explain) __________

### Pursuit Patterns

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**NAME-Last First Middle Attending Physician**

**Record No. Room/Bed**

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# THERAPEUTIC RECREATION/ACTIVITY ASSESSMENT

## ADAPTATIONS FOR ACTIVITY PARTICIPATION OR SKILLS FOR PERSONAL GROWTH

### A. SENSORY:
- [ ] Hearing
- [ ] Vision
- [ ] Taste
- [ ] Touch
- [ ] Smell
- [ ] Needs assistance
- [ ] Needs reminder
- [ ] Needs adapted activity. Specify: __________________________________________________________________
- [ ] Needs adaptive equipment. Specify: ___________________________________________________________________

### B. COGNITIVE:
- [ ] Requires reminders/cues
- [ ] Requires extensive verbal cuing
- [ ] Cannot comprehend instructions
- [ ] Needs adapted activity. Specify: ___________________________________________________________________
- [ ] Needs adaptive equipment. Specify: ___________________________________________________________________

### C. PHYSICAL:
- [ ] Assistance needed getting to and from activity areas: [W/C] [G/C] [Walker] [Other] __________________________________________________________________________
- [ ] Needs adapted activity. Specify: ___________________________________________________________________
- [ ] Needs adaptive equipment. Specify: ___________________________________________________________________

### D. BEHAVIORAL:
- [ ] Needs encouragement
- [ ] Needs re-direction
- [ ] Needs reminders
- [ ] Needs adapted activity. Specify: ___________________________________________________________________
- [ ] Needs adaptive equipment. Specify: ___________________________________________________________________

### E. COMMUNICATION:
- [ ] Primary language, other than English: __________________________________________________________________
- [ ] Cannot initiate conversation
- [ ] Non-verbal
- [ ] Gestures
- [ ] Other
- [ ] Needs adapted activity. Specify: ___________________________________________________________________
- [ ] Needs adaptive equipment. Specify: ___________________________________________________________________

## SPECIAL PRECAUTIONS/CONSIDERATIONS

Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

## ACTIVITY CARE PLAN DECISION

- [ ] Proceed (explain why activity CP is required)
- [ ] Not Proceed (explain why activity CP not required)

Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

## SOURCES OF INFORMATION FOR ASSESSMENT

- [ ] MDS/RAPS/other assessments
- [ ] Progress notes
- [ ] Staff interview
- [ ] Care plans
- [ ] Resident interview
- [ ] Physician consultation
- [ ] Resident observation
- [ ] Family interview
- [ ] Other/identify

Signature/Title: ____________________________ Date: ____________________

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**THERAPEUTIC RECREATION/ACTIVITY ASSESSMENT**