Your Hospital's Logo Here

REHABILITATIVE SERVICES

OCCUPATIONAL THERAPY CONSULTATION

☐ *Hospital* ☐ *Long Term Care*

PATIENT IDENTIFICATION

ADMITTING DIAGNOSIS:

PRIOR LEVEL OF FUNCTION:

SUBJECTIVE:

PAIN INDEX: 1 2 3 4 5 6 7 8 9 10

☐ EDEMA ________ ☐ TONE _________ ☐ HEARING AIDE(S)

VISION: ☐ ADEQUATE ☐ INADEQUATE ☐ CORRECTIVE LENSES / GLASSES

Range of Motion - Upper Extremity	**WITHIN NORMAL LIMITS**		**BELOW NORMAL LIMITS**	
	R	L	R	L
ARM: Shoulder / Elbow				
HAND: Wrist / Fingers				
	INTACT		**IMPAIRED**	
SENSATION				
COORDINATION				
COGNITION				
PERCEPTION				

Strength - Upper Extremity	**WITHIN NORMAL LIMITS**		**BELOW NORMAL LIMITS**	
	R	L	R	L
ARM: Shoulder / Elbow				
HAND: Wrist / Fingers				
Activity Tolerance	**NORMAL**	**GOOD**	**FAIR**	**POOR**
Standing Balance	**GOOD**	**FAIR**	**POOR**	

KEY: **I** = Independent **S** = Supervision **Min A** = Minimal Assitance **Mod A** = Moderate Assistance **Max A** = Maximum Assistance **D** = Dependent **N/A** = Not Assessed **S/U** = Not Assessed **N/T** = Not Tested **CGA** = Contact Guard Assistance

	I	S	CGA	Min A	Mod A	Max A	D	N / T	N / A
Feeds Self									
Grooming / Hygiene									
Bathing:									
Dressing:									
Toileting:									
Bed Mobility:									
Transfer Bed-Chair:									
Toilet Transfer:									

RECOMMENDATIONS

☐ **Patient recommended for Occupational Therapy while in hospital:** **Patient Participation in Goals:** ☐ **Yes** ☐ **No**

Functional goals / Initial Plan of Care

☐ **Bed Mobility** ☐ **Transfers** ☐ **ADL** ☐ **UE Strengthening** ☐ **Safety Awareness** ☐ **Splinting**

☐ **Functional Mobility** ☐ **Cognition** ☐ **Other** ______________________________

☐ **No skilled Occupational Therapy needed while in hospital**

☐ **Patient / Family Education** ______________________________

Splint / DME ______________________________

DISCHARGE RECOMMENDATION as of date of this evaluation

☐ **Home** ☐ **Skilled / Subacute OT**

☐ **Home with OT** ☐ **Acute / Comprehensive OT**

☐ **Outpatient OT** ☐ **Long Term Care**

SIGNATURE: DATE: PAGER / EXTENSION:

PART OF THE MEDICAL RECORD