HOSPITAL

Rehabilitation Services
Occupational Therapy

☐ Initial Evaluation/ ☐ Re-evaluation Specify time billed below:

Date: __________ Time: __________ ___ ADL ___ SNM ___ Splint ___ Cognition/ Perception

Diagnosis: ____________________ Precautions: ____________________

History of Present Illness: ____________________

PMH: ____________________

SH / Home Environment: ____________________

Subjective: ____________________

Cognition / Bx: ☒ Alert ☐ Drowsy ☐ Confused Oriented to: ☐ Person ☐ Place ☐ Time Follows Directions ☐ Verbal ☐ Written ☐ Demonstrated

Vision / Perception: (Circle: WNL / Glasses / Contact Lenses) ____________________

Range of Motion (AROM)- Right UE: ☐ WNL ☐ WFL ☐ Impaired: ______ Left UE: ☐ WNL ☐ WFL ☐ Impaired: ______

Strength (Circle: Right / Left Dominant): ____________________

Edema (Circle: Absent / Min / Mod / Max): __________ Tone: (Circle: WNL / Min / Mod / Max): __________

Motor Control: Gross Motor: ☐ WNL ☐ WFL ☐ Impaired: __________ Fine Motor: ☐ WNL ☐ WFL ☐ Impaired: __________

Sensation: ☐ WNL ☐ Impaired: ____________________

Baseline ADL: ____________________

Current Activities of Daily Living (ADL):

Key: Level of assistance required: I- Independent S- Supervision Min- Minimal CG- Contact Guard Mod- Moderate Max- Maximum D- Dependent

Feeding: ___ *Grooming:* ___ *Bathing / Dressing:* ___ *Getting to bathroom:* ___ *Toileting:* ___

Additional Comments: ____________________

Pain: At rest: ___ / 10, with activity: ___ /10 Pulse Rate: ___ bpm Blood pressure: ___/___

Assessment: ____________________

Long Term Goals: ☐ ↑ ADL independence ☐ ↑ UE functioning ☐ ↑ Cognitive/ perceptual skills to ↑ ADL independence
☐ Independent with splint management ☐ ↑ ADL mobility/ transfers

Short Term Goals: ____________________

Rehab Potential: ☐ Good ☐ Fair ☐ Poor due to: ____________________

Treatment Provided: ☐ ADL's ☐ Sensorineuromuscular ☐ Cognition/perception ☐ Education ☐ Home Program

Recommendations: ☐ Continue skilled OT ☐ Discontinue OT ☐ Refer for Outpatient OT ☐ Other: __________

Patient / Family understands and agrees with treatment program : ☐ yes ☐ no

Patient / Family Education: ____________________

Therapist: ____________________ **Signature/ License:** ____________________

Print Name **Clock #:** __________