Your Hospital's Logo Here

CVA INTERDISCIPLINARY
Team Conference
SUMMARY REPORT

AGE:	ADMISSION DATE:	ROOM #:

PATIENT IDENTIFICATION

CLINICAL STROKE PATHWAY: ☐ YES ☐ NO — PATHWAY DAY: 1 2 3 4 5 6 More — ON TRACK WITH PATHWAY: ☐ YES ☐ NO

NEUROLOGICAL CONSULT: ☐ YES ☐ NO NAME: ________ FINDINGS: ________

CT / MRI / DOPPLER DATE: ________ RESULTS: ________

KEY: **I** = Independent **SBA** = Stand By Assistance **CG** = Contact Guard **MIA** = Minimal Assistance **MOA** = Moderate Assistance **MAA** = Maximum Assistance **D** = Dependent

SUMMARY OF ASSESSMENTS / RECOMMENDATIONS

ADMITTING Dx:

PRE-MORBID STATUS:

STATUS OF UTI:	(________) ________	ANTICOAGULANTS:	(________) ________
	(________) ________		(________) ________

NURSING:

DATE: ________	DATE: ________
LEVEL OF ALERTNESS: Alert / Lethargic ________	LEVEL OF ALERTNESS: Alert / Lethargic ________
ORIENTED: Person / Place / Time ________	ORIENTED: Person / Place / Time ________
ACTIVITY: Bed Bound / Out-of-Bed To Chair ________	ACTIVITY: Bed Bound / Out-of-Bed To Chair ________
PLAN(S) WHILE IN HOSPITAL: ________	PLAN(S) WHILE IN HOSPITAL: ________

PHYSICAL THERAPY:

AMBULATES: Feet ____ Assistance ____ Device ____	AMBULATES: Feet ____ Assistance ____ Device ____
STAIRS: ☐ Y ☐ N ________	STAIRS: ☐ Y ☐ N ________
TRANSFERS: Functional / Limited ________	TRANSFERS: Functional / Limited ________
BED MOBILITY: Functional / Limited ________	BED MOBILITY: Functional / Limited ________
BALANCE: Functional / Limited ________	BALANCE: Functional / Limited ________
PLAN(S) WHILE IN HOSPITAL: ________	PLAN(S) WHILE IN HOSPITAL: ________

OCCUPATIONAL THERAPY:

UPPER EXTREMITY FUNCTION: ________	UPPER EXTREMITY FUNCTION: ________
FEEDING: Can Feed Self / Needs Assistance ________	FEEDING: Can Feed Self / Needs Assistance ________
GROOMING: Independent / Assisted ________	GROOMING: Independent / Assisted ________
DRESSING: Independent / Assisted ________	DRESSING: Independent / Assisted ________
BATHING: Independent / Assisted ________	BATHING: Independent / Assisted ________
TRANSFERS / TOILET: Independent / Assisted ________	TRANSFERS / TOILET: Independent / Assisted ________
TUB TRANSFERS: Independent / Assisted ________	TUB TRANSFERS: Independent / Assisted ________
SAFETY AWARENESS: ________	SAFETY AWARENESS: ________
PLAN(S) WHILE IN HOSPITAL: ________	PLAN(S) WHILE IN HOSPITAL: ________

SPEECH / LANGUAGE & SWALLOWING:

SWALLOW STATUS: Normal / Dysphagia: ________	SWALLOW STATUS: Normal / Dysphagia: ________
FOOD: Texture ________ Liquid ________	FOOD: Texture ________ Liquid ________
SWALLOW FUNCTION STUDY: Done / Indicated / Not Indicated ________	SWALLOW FUNCTION STUDY: Done / Indicated / Not Indicated ________
SPEECH: Functional / Deficits ________	SPEECH: Functional / Deficits ________
LANGUAGE: Functional / Deficits ________	LANGUAGE: Functional / Deficits ________
COGNITIVE / LINGUISTIC SKILLS: Functional / Deficits ________	COGNITIVE / LINGUISTIC SKILLS: Functional / Deficits ________
FUNCTIONAL COMMUNICATION: Yes / No / Partial ________	FUNCTIONAL COMMUNICATION: Yes / No / Partial ________
PLAN(S) WHILE IN HOSPITAL: ________	PLAN(S) WHILE IN HOSPITAL: ________

DIETARY: DATE: ______________ DATE: ______________

DIET ORDER ______ APPETITE: Good / Fair / Poor ______ TUBE FEEDING: ☐ Y ☐ N NUTRITIONAL STATUS: ☐ Caloric Deficiency / Mixed Protein ☐ Not Nutritionally Depleted ☐ Caloric Deficiency ☐ Hypo-Albuminemia ☐ Unable to Determine OTHER: ______	DIET ORDER ______ APPETITE: Good / Fair / Poor ______ TUBE FEEDING: ☐ Y ☐ N NUTRITIONAL STATUS: ☐ Caloric Deficiency / Mixed Protein ☐ Not Nutritionally Depleted ☐ Caloric Deficiency ☐ Hypo-Albuminemia ☐ Unable to Determine OTHER: ______

CASE MANAGEMENT:

INSURANCE: ______ DISPOSITION: ______ PLAN: ______ OTHER: ______	INSURANCE: ______ DISPOSITION: ______ PLAN: ______ OTHER: ______

DISCHARGE RECOMMENDATIONS BY THE TEAM:

☐ RETURN HOME ______ ☐ HOME SERVICES ______ ☐ OUT-PT REHAB ______ ☐ HOME HEALTH CARE SVCS ______ ☐ ACUTE REHAB PLACEMENT ______ ☐ SHORT-TERM CARE / SUB-ACUTE PLACEMENT ______ ☐ LONG TERM CARE PLACEMENT ______ ☐ EQUIPMENT NEEDS ______ ☐ EDUCATION NEEDS ______	☐ RETURN HOME ______ ☐ HOME SERVICES ______ ☐ OUT-PT REHAB ______ ☐ HOME HEALTH CARE SVCS ______ ☐ ACUTE REHAB PLACEMENT ______ ☐ SHORT-TERM CARE / SUB-ACUTE PLACEMENT ______ ☐ LONG TERM CARE PLACEMENT ______ ☐ EQUIPMENT NEEDS ______ ☐ EDUCATION NEEDS ______

DISCHARGE RECOMMENDATIONS TO ATTENDING MD (SEE PROGRESS NOTES FOR DETAILS BY EACH DISCIPLINE) BARRIERS TO DISCHARGE:	**DISCHARGE RECOMMENDATIONS TO ATTENDING MD** (SEE PROGRESS NOTES FOR DETAILS BY EACH DISCIPLINE) BARRIERS TO DISCHARGE:

CASE MANAGEMENT:

Nursing: ______ Physical Therapy: ______ Occupational Therapy: ______ Speech / Language Pathology: ______ Dietary: ______ Case Management: ______ CM Representative: ______ Other(s) in Attendance: ______	Nursing: ______ Physical Therapy: ______ Occupational Therapy: ______ Speech / Language Pathology: ______ Dietary: ______ Case Management: ______ CM Representative: ______ Other(s) in Attendance: ______