Subjective: _____

O: ASSESSED: ☐ Bedside ☐ Department
Lines/Equipment: ☐ IV Left/Right site _____ ☐ Foley/Texas catheter ☐ O2 at _____ L/min ☐ Other _____
Pain: Rate (0 - 10 scale) _____ Comments: _____

MENTAL STATUS: Orientation: ☐ Person ☐ Place ☐ Time ☐ Circumstance
Level of Alertness: ☐ Alert ☐ Lethargic ☐ Unresponsive
Follows Commands: ☐ One Step ☐ Two Step ☐ _____
General Comments: _____

VISION/PERCEPTION: _____

UPPER EXTREMITY: Dominance: ☐ Right ☐ Left Involved Extremity: ☐ Right ☐ Left ☐ Not Applicable
ROM: _____
Strength: _____
Sensation: _____
Coordination: _____
Comments: Pain/Edema/ Tone/ Motor Control/Contractures _____

LOWER EXTREMITY: _____
Mobility Device: _____ Weight Bearing Status: ☐ NWB ☐ Touch ☐ Partial ☐ As tol ☐ Full ☐ Not Applicable ☐ Right ☐ Left

TRUNK/SITTING BALANCE: _____

ACTIVITIES OF DAILY LIVING: Key I=Independent ModI = Modified Independent S= Supervision
NT = Not Tested MinA = Minimal Assistance ModA= Moderate Assistance Max A = Maximal Assistance Dep = Dependent

SELF CARE	PRESENT STATUS	COMMENTS	FUNCTIONAL MOBILITY /TRANSFERS	PRESENT STATUS	COMMENTS
Feeding			Bed Mobility		
Grooming			Sit to Stand		
Bathing - Upper Body			Bed to Chair		
Bathing - Lower Body			Toilet Transfer		
Dressing - Upper Body			Tub/Shower Transfer		
Dressing - Lower Body			Other:		
Toileting					

TREATMENT: Patient Instructed ☐ ADLs ☐ Transfers ☐ Adaptive Equip. ☐ THR Precautions ☐ Energy Conservation ☐ Safety Considerations in the home
☐ Other _____
Activity tolerance ☐ low ☐ fair ☐ good ☐ normal _____
ASSESSMENT: O.T. findings include _____
LEVEL OF UNDERSTANDING OF INSTRUCTION: ☐ poor ☐ fair ☐ good Comments _____
PLAN: _____

PATIENT/CAREGIVER EDUCATION

LEARNING NEEDS	METHODS OF INSTRUCTION	EVALUATION OF EFFECTIVENESS
☐ ADLS ☐ Functional mobility	☐ Demo ☐ verbal ☐ written	Return Demo

SHORT TERM GOALS

1. Pt will
2. Pt will
3. Pt will

LONG TERM GOALS

1. Pt will

Patient / Family agrees to participate in therapy ☐ Yes ☐ No Explain _____
Patient / Family goal(s) _____

D/C PLANS / EQUIPMENT

Plans at Discharge: ☐ Home ☐ Home with supervision ☐ Home OT ☐ Outpatient OT ☐ Subacute ☐ Comprehensive Rehab ☐ Skilled Nursing Facility
Equipment Needed: ☐ No ☐ Yes Issued ☐ No ☐ Yes _____ (Specify)

Signature, Title _____ License No.: _____ Date _____ Time _____ Duration _____

Patient Identification

Hospital

OCCUPATIONAL THERAPY ASSESSMENT AND PLAN OF CARE

9970-181 (12/02)