Clear Form

OCCUPATIONAL THERAPY EVALUATION RecoverHealth *We bring health care home*

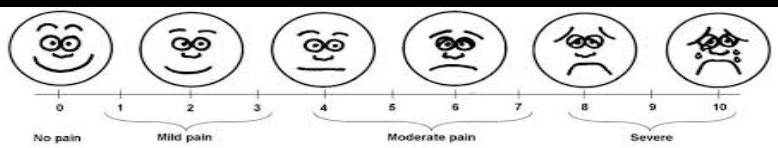
CLIENT NAME	**SERVICE DATE** **DOB**	**BRANCH**	**TIME IN:** **TIME OUT:**

HOMEBOUND REASON (*check one*): ☐ Dependent on adaptive device(s) ☐ Requires assistance to ambulate
☐ Severe pain ☐ Medical Restrictions ☐ Severe SOB with _____
☐ Other (specify)_____
(MANDATORY) **UNABLE TO LEAVE HOME SAFELY DUE TO:** _____
_____

PERTINENT BACKGROUND INFORMATION

PRIMARY MEDICAL DIAGNOSIS: _____**Onset:** _____
PERTINENT MEDICAL HISTORY:
_____
GENERAL PRIOR LEVEL OF FUNCTION:
_____
LIVING SITUATION / SUPPORT SYSTEM: ☐Capable, willing caregiver available ☐Limited caregiver (ability/willingness)
☐ No caregiver available _____
HOME / SAFETY BARRIERS: ☐ Uneven floors/doorsills ☐ Poor lighting ☐ Indoor pets ☐ Improper/unsafe footwear
☐ Structural barriers (lack of handrails, stairs) ☐ Scatter rugs / loose carpet ☐ Cords through walkways
☐ Tubing (oxygen, catheter) ☐ Tub/Shower access ☐ Other:_____

MEDICATIONS REVIEWED? ☐ Yes ☐ No **COMPLIANT WITH MED REGIMEN?** ☐ Yes ☐ No	**ANY NEW/CHANGED MEDICATIONS?** ☐ Yes ☐ No If Yes, document change: _____ If Yes, Medication profile updated? ☐ Yes ☐ No

VITAL SIGNS	**PAIN**
BP: ____/____ ☐ ***Sitting*** ☐ ***Standing*** ☐ ***Supine***	 _____/10
BP: ____/____ ☐***Sitting*** ☐***Standing*** ☐ ***Supine***	
Pulse: ____ ☐**Regular** ☐**Irregular**	**Pain Location:** _____ **Pain Description:** _____
Oxygen Saturation: ____%	**Aggravating Factors:** _____ **Alleviating Factors:** _____

SENSORY / FACTORS IMPACTING FUNCTION

☐**Alert** ☐**Oriented x** _____ ☐ **Cooperative** ☐ **Confused** ☐ **Memory deficits** ☐ **Impaired judgement**

COGNITION	
SKIN/INTEGUMENTARY	
EDEMA: location, severity	
VISION OR HEARING	
SAFETY AWARENESS	

MUSCLE STRENGTH/FUNCTIONAL ROM

STRENGTH (joint, side (R/L) or functional test)	
MOTOR COORINDATION (Fine, gross, side (R/L)	
ROM (active, passive, joint, side (R/L))	
AMBULATION (level of assist, device, distance)	
Comments:	

CLIENT NAME	SERVICE DATE	BRANCH

Code the patient's usual performance at evaluation for each activity using the 6-point scale. If activity was not attempted at evaluation, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06.**Independent** – Patient completes the activity by him/herself with no assistance from a helper
05.**Set-up or clean-up assistance** – helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04.**Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03.**Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs and provides, but provides less than half the effort.
02.**Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01.**Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2or more helpers is required for the patient to complete the activity.
If activity was not attempted, code reason
07.**Patient Refused**
09.**Not applicable** – not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10.**Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88.**Not attempted due to medical conditions or safety concerns**

Evaluation Performance	Discharge Goal	
		Eating: The ability to use suitable utensils to bring food and / or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
		Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): the ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
		Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
		Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
		Upper Body Dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
		Lower Body Dressing: The ability to dress and undress below the waist; including fasteners; does not include footwear.
		Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility, including fasteners, if applicable.

Comments:

Functional Areas	Prior Level of Function (PLOF)	Current Level of Function (CLOF)	Goal	CLOF (minus) Goal	Scoring Key: **The level of ability refers to the level of assistance (if any) that the patient requires to *SAFELY* complete a specified task.**
Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).					0 = Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 = Grooming utensils must be placed within reach before able to complete grooming activities. 2 = Someone must assist the patient to groom self. 3 = Patient depends entirely upon someone else for grooming needs.
Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:					0 = Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 = Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 = Someone must help the patient put on upper body clothing. 3 = Patient depends entirely upon another person to dress the upper body.
Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:					0 = Able to obtain, put on, and remove clothing and shoes without assistance. 1 = Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 = Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 = Patient depends entirely upon another person to dress lower body.

CLIENT NAME					SERVICE DATE	BRANCH
Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.					0 = Able to get to and from the toilet and transfer independently with or without a device. 1 = When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. 2 = Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3 = Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. 4 = Is totally dependent in toileting.	
Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**					0 = Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1 = With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2 = Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 = Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 = Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5 = Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6 = Unable to participate effectively in bathing and is bathed totally by another person.	
When is the patient dyspneic or noticeably **Short of Breath**?					0 = Patient is not short of breath 1 = When walking more than 20 feet, climbing stairs 2 = With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 = With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 = At rest (during day or night)	
Frequency of Pain Interfering with patient's activity or movement:					0 = Patient has no pain 1 = Patient has pain that does not interfere with activity or movement 2 = Less often than daily 3 = Daily, but not constantly 4 = All of the time	
Objective Measure					**Forward Functional Reach Test (FFRT): (3)** Unwilling to reach = risk of falling 8x > norm; **(2)** <6" = risk of falling 4x > norm; **(1)** 6"-10" = risk of falling 2x > norm; **(0)** > 10" = low risk of falling **Sitting Forward Functional Reach Test (SFRT):** 40-59 y.o. **(0)** ≤ 15.9" and **(1)** > 15.9"; 60-79 y.o. **(0)** ≤ 13.2" and **(1)** > 13.2"; 80-97 y.o. **(0)** ≤ 12.5" and **(1)** > 12.5" **Other:**	
Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**					0 = Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1 = Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 = Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3 = Unable to take medication unless administered by another person. NA = No oral medications prescribed.	
Did patient receive post-acute (skilled nursing facility, inpatient rehabilitation facility, long term care hospital, or inpatient psychiatric facility) **care in the 14 days prior to the HH admission**					Yes = 2 No = 0	
Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)** *INSTRUCTION: 1 POINT FOR EACH RISK IDENTIFIED*					☐ - History of falls (2 or more falls – or any fall with an injury – in the past 12 months) ☐ - Multiple hospitalizations (2 or more) in the past 6 months ☐ - Diagnosis of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, or Diabetes Mellitus	
					←Sum of column (CDCP Score)	

CLIENT NAME	EVALUATION DATE	BRANCH	PHYSICIAN NAME

☐ INITIAL EVALUATION ☐ RE-EVALUATION CLIENT SIGNATURE:

Primary Diagnosis & Reason for OT: _____

_____ Onset: _____

Frequency & Duration of OT POC: _____ effective week of: _____

OCCUPATIONAL THERAPY INTERVENTIONS

	Evaluation		Manual therapy techniques		Establish home exercise program ☐ Copy given to client ☐ Copy attached to chart
	Therapeutic exercise to develop strength, flexibility, range-of-motion		Development of cognitive skills to improve attending, problem-solving		
	Neuromuscular reeducation of movement, balance, coordination		Sensory reintegration to enhance responses to environmental demands		WC Management (assessment/fitting when not otherwise reported, training)
	Therapeutic activities to improve functional performance		Self-care/home management training & compensatory training		Orthotic(s) management & training of UE, LE &/or trunk
	Pain management strategies		Other: _____		Checkout for Orthotic use

ANALYSIS / CARE PLANNING / TREATMENT

☐ OT Evaluation only. No further indications for service

☐ Client appropriate for additional services; Need verbal orders

Instruction provided this date: ☐ Safety training
☐ Exercise ☐ Other: _____
☐ Equipment Needs: _____
_____

☐ Refer to _____ for evaluation.

DISCHARGE PLANNING DISCUSSED WITH: ☐ Patient
☐ Family ☐ Physician ☐ Care Manager ☐ Other
(specify) _____

CARE COORDINATION: ☐ Physician ☐ SN ☐ PTA ☐ OT
☐ ST ☐ HHAide ☐ ALF Staff ☐ Other: _____

APPROXIMATE NEXT VISIT DATE: ____/____/____

GOALS FOR OCCUPATIONAL THERAPY

CLIENT/CAREGIVER'S DESIRED OUTCOMES FROM O.T.:

All goals to be written in SMART format: Specific, Measurable, Attainable/Achievable, Relevant, Time-Bound.

GROOMING	**Short term** ☐ **Long term** ☐	
UPPER BODY DRESSING	**Short term** ☐ **Long term** ☐	
LOWER BODY DRESSING	**Short term** ☐ **Long term** ☐	
TOILET TRANSFERRING	**Short term** ☐ **Long term** ☐	
BATHING	**Short term** ☐ **Long term** ☐	
DYSPNEA	**Short term** ☐ **Long term** ☐	**Patient will demonstrate increased endurance/tolerance with ability to _____ _____ with no signs or symptoms of breathlessness.**
PAIN INTERFERING	**Short term** ☐ **Long term** ☐	**Patient will demonstrate effective pain control through _____, reducing pain from __/10 to __/10, allowing for _____**
OBJECTIVE MEASURE	**Short term** ☐ **Long term** ☐	
MEDICATION MANAGEMENT	**Short term** ☐ **Long term** ☐	
HEP COMPLIANCE	**Short term** ☐ **Long term** ☐	**Patient will demonstrate ability to perform Home Exercise Program independently, or with assist of caregiver, resulting in improvements in _____**
HOSPITALIZATION PREVENTION	**Short term** ☐ **Long term** ☐	**Patient will understand how and when to contact Recover Health clinicians, and will demonstrate ability to maintain medical condition in home without unplanned hospitalization or ER visit.**
OTHER	**Short term** ☐ **Long term** ☐	

Short term goals to be achieved in _____ weeks

Long term goals to be achieved in _____ weeks

REHAB POTENTIAL: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Due to: _____

DISCHARGE PLAN: Discontinue Occupational Therapy when client meets goals or reaches maximum rehab potential.

Client / Caregiver aware of POC & agreeable to POC: ☐ **Yes** ☐ **No (explain)**_____

Plan developed by: _____ **Date:** _____ **Time:** _____
Professional signature and title

OCCUPATIONAL THERAPY CARE PLAN & PHYSICIAN'S ORDERS

Verbal Orders received from _____ **by:** _____ **Date:** _____ **Time:** _____
MD Phone Number: _____ ***Professional signature & title*** ☐ Orders read back & verified
Physician Signature: _____ **Date:** _____ **Time:** _____
Please sign & return promptly