Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

OT Evaluation

Patient Name: Test Patient **MR:** XXXX **Visit Date:** 6/7/2018

Episode Period: 06/05/2018 - 08/03/2018 **Time In:** 07:00 AM **Time Out:** 07:30 AM

Associated Mileage: **Surcharge:** **Physician:** Test Physician MD

Vital Signs

SBP	DBP	HR	Resp	Temp	Weight	O2 Sat
126	79	76	12			

PLOF and Medical History

Prior Level of Function

Patient recently moved to ALF, and experiencing difficulty in word finding

Pertinent Medical History

Living Situation

Dwelling Level One ☐ Multiple

Stairs #steps ___ ☐ Yes No

Lives with

☐ Alone ☐ Family ☐ Friends ☐ Significant Other

Support:

Willing caregiver available ☐ Limited caregiver support ☐ No caregiver available

Home Safety Barriers:

Homebound Reason

Requires considerable and taxing effort. ☐ Medical restriction.

Needs assist with transfer. ☐ Needs assist with ambulation.

☐ Needs assist leaving the home. ☐ Unable to be up for long period.

☐ Severe SOB upon exertion. ☐ Unsafe to go out of home alone.

ADLs/Functional Mobility Level/Level of Assist

I.FUNCTIONAL MOBILITY	Assistance	Assistive Device
Bed mobility	____	____
Bed/WC transfers	____	____
Toilet transfer	____	____
Tub/shower transfer	____	____

Comment

Max bed mob

DEP Transfers with mechanical lift and 2 caregivers

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician OT 6/7/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

OT Evaluation

Patient Name: Test Patient **MR:** XXXX **Visit Date:** 6/7/2018

Episode Period: 06/05/2018 - 08/03/2018 **Time In:** 07:00 AM **Time Out:** 07:30 AM

Associated Mileage: **Surcharge:** **Physician:** Test Physician MD

ADLs/Functional Mobility Level/Level of Assist

II.SELFCARE/ADL SKILLS	Assistance	Assistive Device
Self Feeding	____	____
Oral Hygiene	____	
Grooming	____	
Toileting	____	
UB bathing	____	____
LB bathing	____	____
UB dressing	____	____
LB dressing	____	____
Comment		

III.INSTRUMENTAL ADL	Assistance	Assistive Device
Housekeeping	____	____
Meal prep	____	____
Laundry	____	____
Telephone use	____	____
Money management	____	____
Medication management	____	____
Comment		

	Static	Dynamic
Sitting Balance	____	____
Stand Balance	____	____

Physical Assessment

Part	Action	ROM Right	ROM Left	Strength Right	Strength Left
Shoulder	Flexion				
	Extension				
	Abduction				
	Int Rot				
	Ext Rot				
Elbow	Flexion				
	Extension				

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician OT 6/7/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

OT Evaluation

Patient Name: Test Patient **MR:** XXXX **Visit Date:** 6/7/2018

Episode Period: 06/05/2018 - 08/03/2018 **Time In:** 07:00 AM **Time Out:** 07:30 AM

Associated Mileage: **Surcharge:** **Physician:** Test Physician MD

Physical Assessment

Finger	**Flexion**				
	Extension				
Wrist	**Flexion**				
	Extension				
Trunk	**Flexion**				
	Rotation				
	Extension				
Neck	**Flexion**				
	Extension				
	Lat Flexion				
	Long Flexion				
	Rotation				

Comment

AROM of RUE impaired
AROM of LUE WFLs
LUE Strength 3+/5

Pain Assessment

Pain Location NA **Pain Level** 0

Increased by **Relieved by**

Sensory/Perceptual Skills

	Sharp/Dull		Light/Firm	Touch	Proprioception	
Area	**Right**	**Left**	**Right**	**Left**	**Right**	**Left**

Visual Skills: Acuity

Intact ☐ Impaired ☐ Double ☐ Blurred

Tracking:

Unilaterally ☐ Bilaterally ☐ Smooth ☐ Jumpy ☐ Not Tracking

Visual Field Cut or Neglect Suspected

☐ Right ☐ Left

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician OT 6/7/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

OT Evaluation

Patient Name: Test Patient **MR:** XXXX **Visit Date:** 6/7/2018

Episode Period: 06/05/2018 - 08/03/2018 **Time In:** 07:00 AM **Time Out:** 07:30 AM

Associated Mileage: **Surcharge:** **Physician:** Test Physician MD

Sensory/Perceptual Skills

Impacting Function?

☐ Yes ☐ No (Specify): _____

Referral Needed?

☐ Yes ☐ No (Who contacted): _____

Cognitive Status/Comprehension

Memory:Short term		**Sequencing**	
Memory:Long term		**Problem Solving**	
Attention/Concentration		**Coping Skills**	
Auditory Comprehension		**Able to Express Needs**	
Visual Comprehension		**Safety/Judgment**	
Self-Control		**Initiation of Activity**	

Comments

Moderate impairment post CVA

Motor Components(Enter Appropriate Response)

Fine Motor Coordination	Right	
	Left	
Gross Motor Coordination	Right	
	Left	

☐ Right handed ☐ Left handed ☐ Orthosis ☐ Used

☐ Needed(specify) _____

Comments

RUE impaired

Assessment

A/O to self, able to intermittently follow instructions

Narrative

Facilitated home safety assessment with recommendations RE patient safety, able to return demo understanding with consistent cueing.

Test STEST

Standardized test

Prior	Current

Clinician Signature: Electronically Signed by: Test Clinician OT

Date: 6/7/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

OT Evaluation

Patient Name: Test Patient **MR:** XXXX **Visit Date:** 6/7/2018

Episode Period: 06/05/2018 - 08/03/2018 **Time In:** 07:00 AM **Time Out:** 07:30 AM

Associated Mileage: **Surcharge:** **Physician:** Test Physician MD

Standardized test

Katz Index:		**Katz Index:**	
9 Hole Peg Test:		**9 Hole Peg Test:**	
Lawton & Brody IADL Scale:		**Lawton & Brody IADL Scale:**	
Mini-Mental State Exam:		**Mini-Mental State Exam:**	
Other:	:	**Other:**	:

MD Orders

DME

☐ N/A

Available: W/C, Mechanical Lift

Needs: _____

Suggestion: _____

Diagnosis

Medical Diagnosis: CVA with R Hemiplegia **Onset** _____

OTDiagnosis: Muscle weakness **Onset** _____

Comment

_____

Treatment Plan

OT Frequency & Duration:

2w1, 3 w 2, 1 w 1 eff 6/7

Therapeutic exercise

☐ Neuromuscular re-education

☐ Teach fall prevention/safety

Pt/caregiver education/training

☐ Postural control training

☐ Wheelchair management training

☐ Teach work simplification

Self care management training

☐ Teach task segmentation

☐ Electrical stimulation

☐ Ultrasound

Therapeutic activities (reaching, bending, etc)

Teach safe and effective use of adaptive/assist device

☐ Establish/upgrade home exercise program

☐ Sensory integrative techniques

☐ Teach energy conservation techniques

☐ Teach safe and effective breathing technique

☐ Community/work integration

☐ Cognitive skills development/training

☐ Manual therapy techniques

Body Parts: _____ **Duration:** _____

Body Parts: _____ **Dosage:** _____ **Duration:** _____

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician OT 6/7/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

OT Evaluation

Patient Name: Test Patient **MR:** XXXX **Visit Date:** 6/7/2018

Episode Period: 06/05/2018 - 08/03/2018 **Time In:** 07:00 AM **Time Out:** 07:30 AM

Associated Mileage: **Surcharge:** **Physician:** Test Physician MD

Treatment Plan

Other

Modalities

☐ N/A

OT Goals

Additional goals:

Rehab Potential:

OT Short Term Goals:

Min bed mobility rolling side to side
Min bed mob supine to EOB
Patient and staff to return demo understanding of HEP for PROM of RUE, AAROM of RUE where indicated
4/5 LUE strength
Mod I grooming and hygiene, self feeding with AE PRN

OT Long Term Goals:

Meet STGs

Patient Caregiver desired outcomes:

Other Discipline Recommendation

☐ N/A

☐ PT ☐ MSW ☐ ST ☐ Podiatrist **Other**

Reason

Rehab

☐ N/A

Rehab Diagnosis: Muscle weakness

Rehab Potential: ☐ Good ☐ Fair ☐ Poor

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician OT 6/7/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

OT Evaluation

Patient Name: Test Patient **MR:** XXXX **Visit Date:** 6/7/2018

Episode Period: 06/05/2018 - 08/03/2018 **Time In:** 07:00 AM **Time Out:** 07:30 AM

Associated Mileage: **Surcharge:** **Physician:** Test Physician MD

Discharge Plan

☐ N/A

Patient to be discharged to the care of ☐ Physician Caregiver ☐ Selfcare

Discharge Plans ☐ Discharge when caregiver willing and able to manage all aspects of patient's care. ☐ Discharge when goals met.

Skilled Care Provided

☐ N/A

Training Topics

Trained: ☐ Patient ☐ Caregiver

Treatment Performed:

Facilitate home safety assessment with recommendations RE safety

Patient Response:

Return demo understanding with consistent cueing

Care Coordination	Safety Issues/Instruction/Education
☐ N/A COTA RE CARE PLAN	☐ N/A

Notification

Patient Caregiver

Understands diagnosis/prognosis and agrees with Goals/Time frame and Plan of Care (POC)

☐ Yes ☐ No

☐ Physician notified and agrees with POC, frequency and duration. Comments (if any):

Treatment Performed

Narrative

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician OT 6/7/2018