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OCCUPATIONAL THERAPY EVALUATION NOTE

Type of Evaluation: ☐30 Day Visit ☐ROC ☐REC ☐Supervisory Visit ☐Other: **SOC Date:** 05/22/2018

HOMEBOUND REASON

- ☑ Needs assistance for all activities
- ☑ Residual weakness
- ☐ Requires assistance to ambulate
- ☐ Unable to safely leave home unassisted
- ☐ Other:
- ☐ Dependent upon adaptive device(s)
- ☐ Confusion, unable to go out of home alone
- ☐ Severe SOB, SOB upon exertion
- ☐ Medical restrictions

VITAL SIGNS

B/P: ___/___ PR:
RR: Temp:
02: LPM via:

PERTINENT MEDICAL INFORMATION

Primary Diagnosis: Onset 05/22/2018

MUSCLE WEAKNESS, ADL DEFICITS

Medical Precautions / Limitations:

Pain: Rating scale (No pain 0 - 10 Worst pain) 0 Pain location: NA
Pain (describe):
Frequency: ☐Occasionally ☐Continuous ☐Intermittent ☐Other:
What makes pain worse? ☐Movement ☐Ambulation ☐Immobility
Referral needed? ☐Yes ☐No Referred to:

PERTINENT BACKGROUND INFORMATION

Prior Level of Functioning with ADLs: ☑Independent ☐Needed Assist ☐Total Assist **History of Falls:** ☐No ☐Yes, date
Intervention in place? ☐No ☐Yes, specify: Reported by: ☐Patient ☐Family ☐Caregiver
Support System: ☑Lives alone ☑Caregiver available ☐Limited support ☐No caregiver available
Comment:
Environmental Barriers: ☐Clutter ☐Throw rugs Adaptive equipment needed: ☐No ☐Yes, type:
Other:

SKILLED INTERVENTIONS

- ☐ Cognition
- ☐ Sensory Treatment
- ☐ Patient Education
- ☐ Orthotic/Splinting
- ☑ Home Safety Education
- ☐ Fine Motor (Coordination)
- ☐ Perceptual Motor Training
- ☐ Visual/Perceptive Skills
- ☐ Adaptive Equipment Training
- ☐ Neuro-developmental Treatment
- ☑ Therapeutic Exercises for UE's
- ☑ Establish Home Exercise Program
- ☑ Activities of Daily Living (ADL) Training
- ☐ Other:

...more

KEY: I - Intact, MIN - Minimally Impaired, MOD - Moderately Impaired, S - Severely Impaired, U - Untested/Unable to test

SENSORY / PERCEPTUAL MOTOR SKILLS

AREA	Sharp / Dull		Light / Firm Touch		Proprioceptions	
	Right	Left	Right	Left	Right	Left
BUES WFLS						

Visual Skills: **Acuity** ☑Intact ☑Impaired ☐Double ☐Blurred
Tracking: ☐Unilaterally ☐Bilaterally ☐Smooth ☐Jumpy ☐Not Tracking
Visual Field Cut or Neglect Suspected: ☐Right ☐Left
Impacting Function? ☐No ☐Yes, specify:
Referral Needed? ☐No ☐Yes, who contacted?

MOTOR COMPONENTS

Fine Motor Coordination	Impaired	Intact	Functional	Gross Motor Coordination	Impaired	Intact	Functional
Right		x		Right		x	
Left		x		Left		x	

☐Right handed ☐Left handed ☐Orthosis ☐Used ☐Needed (specify):

COGNITIVE STATUS / COMPREHENSION

ORIENTED: ☐Person ☐Place ☐Time ☐Reason for Therapy:

Deficit Area	Impaired	Intact	Functional	Deficit Area	Impaired	Intact	Functional
MEMORY: Short term		x		Sequencing		x	
Long term		x		Problem Solving		x	
Attention / Concentration		x		Coping Skills		x	
Auditory Comprehension		x		Able to Express Needs		x	
Visual Comprehension		x		Safety / Judgment		x	
Self-Control		x		Initiation of Activity		x	

Patient Name: Test Patient **MR#:** #0000000000

5/23/2018 10:15 AM – 10:45 AM | Test Clinician | Type: OT Evaluation(G0160) | Insurance: Medicare | Episode Period: 05/22/

MANUAL MUSCLE TEST AND RANGE OF MOTION

Extremities			Strength L	Strength R	ROM L	ROM R	Extremities			Strength L	Strength R	ROM L	ROM R
Shoulder	Flexion	0-180	3	3	WFLS	WFLS	Elbow	Flexion	0-145	3	3	WFLS	WFLS
	Extension	0-45	3	3				Extension	0	3	3		
	Abduction	0-180	3	3			Wrist	Flexion	0-80	3	3		
	Int Rot	0-70	3	3				Extension	0-70	3	3		
	Ext Rot	0-90	3	3				Fingers		3	3		

OBJECTIVE DATA TESTS AND SCALES

Manual Muscle Tests (MM) Muscle Strength

Grade	Description
5	Normal functional strength - against gravity - full resistance.
4	Good strength - against gravity with some resistance.
3	Fair strength - against gravity - no resistance - safety compromise.
2	Poor strength - unable to move against gravity.
1	Trance strength - slight muscle contraction - no motion.
0	Zero - no active muscle contraction.

Functional Independence, Self-care Skills and Instrumental ADL Scale

Grade	Description
5	Physically able and does task independently
4	Verbal cue (PVC) only needed.
3	Stand-by assist (*SBA) - 100% patient / client effort.
2	Minimum assist (Min A) - 75% patient / client effort.
1	Maximum assist (Max A) - 25% - 50% patient / client effort.
0	Total dependent - total care.

TASKS	SCORE	COMMENTS	TASKS	SCORE	COMMENTS
Functional Mobility / Balance Evaluation					
Bed Mobility	2		Dynamic Sitting Balance	2	
Bed/Wheelchair Transfer	2		Static Sitting Balance	2	
Toilet Transfer	2		Static Standing Balance	2	
Tub/Shower Transfer	2	...more	Dynamic Standing Balance	2	...more
Self Care Skills					
Feeding	5		Toileting	2	
Swallowing	5		Bathing	2	
Food to Mouth	5		UE Dressing	2	
Oral Hygiene	5		LE Dressing	2	
Grooming	5	...more	Manipulation of Fasteners	2	...more
Instrumental ADLs					
Light Housekeeping	1		Use of Telephone	1	
Light Meal Preparation	1		Money Management	1	
Clothing Care	1	...more	Medication Management	1	...more

SUMMARY

☐ OT evaluation only. No further indications for service: ☐ No ☐ Yes

Was a standardized/validated assessment used? ☐ No ☐ Yes, specify assessment: _____

Results: _____

☐ Orders for OT evaluation only. Additional services needed: ☐ No ☐ Yes, specify: _____ See POC

☑ Complete orders for OT services with specific treatments, frequency and duration. See POC / 485.

Other disciplines providing care: ☐ SN ☐ OT ☐ ST ☐ MS ☐ Aide ☐ Other (specify): _____

Instruction/ Education provided: ☐ Yes ☐ No ☐ Safety ☐ Exercise ☐ Other (specify): _____

☐ Equipment recommendations (specify): _____

☐ There are no changes to the POC based upon this assessment, at this time.

Was a need identified or reported during this assessment in any of the following areas that requires a referral?

☐ Nutrition ☐ Medications ☐ Pain ☐ Injuries / Wounds ☐ Psychosocial concerns

☐ Self care skills ☐ ADLs ☐ Safety issues ☐ Other: _____

☐ No ☐ Yes, specify: _____

☐ Referral recommendations (specify): _____

Comments:

...more

☑ Patient/PC informed of Next Visit Date: 5/24

Plan for Next Visit:

HEP initiation

...more

☐ Discharge Plan discussed with Patient/PC

Communication w/: ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ Aide ☐ Case Manager

Regarding: _____

OT Supervisory Visit: ☐ Present ☐ Absent

Observation/Teachings of: _____

Patient Name: Test Patient **MR#:** #0000000000

NEW PROBLEMS

Date:	Problems/Goals/Interventions:	Disciplines involved:	Source:	Last Updated:

Patient Name: Test Patient MR#: #0000000000