



# GEM STAFFING

## Occupational Therapy Evaluation p1

<b>PATIENT</b>					<b>SOC:</b>								
RECORD#:			DATE:		TIME IN:			TIME OUT:					
DIAGNOSIS:													
<b>PROBLEMS</b>					<b>FUNCTIONAL GOALS</b>								
1					1								
2					2								
3					3								
4					4								
<b>OCCUPATIONAL THERAPY PLAN OF TREATMENT</b>					The O.T. Plan of Treatment is recommended pending physician's approval: _____, O.T.R.								
1					The O.T. Plan of Treatment is amended and/or								
2					approved by: _____ Date: _____								
3					(Physician's Name)								
4													
<b>PLAN: CONTINUE AT _____ FREQUENCY FOR _____ WEEKS</b>													
<b>MENTAL STATUS (CIRCLE if impaired):</b>													
ORIENTATION / ATTENTION SPAN / MOTIVATION / MEMORY / FOLLOW DIRECTION / JUDGEMENT													
PART	ACTION	STRENGTH		ROM		PART	ACTION	STRENGTH		ROM		MUSCLE GRADES:	ROM is graded by
		R	L	R	L			R	L	R	L		
SHOULDERS	ABDUCTION					WRIST	FLEXION					G - Good    T - Trace F - Fair    0 - Zero C = Complete IC = Incomplete  Comments:            Pain, Edema, Tone, Synergy, Functional uses:	
	ADDUCTION						EXTENSION						
	FLEXION					FINGER	GRIP						
	EXTENSION						EXTENSION						
	INTERNAL ROTATION						HAND DOMINANCE						
EXTERNAL ROTATION													
ELBOW	FLEXION					TRUNK / BALANCE							
	EXTENSION												
FOREARMS	SUPINATION					FINE MOTOR							
	PRONATION												
SENSATION						PERCEPTION							
HOME ASSESSMENT						EQUIPMENT							
FEEDING						HYGIENE							
BATHING						TRANSFERS							
DRESSING: 0 - UNABLE 1 - PHYSICAL ASSIST 2 - SUPERVISION 3 - INDEPENDENT N/A - NOT APPLICABLE													
SHIRT:						HOUSEHOLD ACTIVITIES/HOBBIES							
SLACKS:													
SOCKS:													
SHOES:													
FASTENINGS:													
EVALUATED BY / SIGNATURE / TITLE						PATIENT'S SIGNATURE							



# GEM STAFFING

## Occupational Therapy Evaluation p2

### REHABILITATION GOALS

OT

PATIENT

PROJECTED NUMBER OF VISITS:

#### Home Bound Reason

- Needs Assistance for all activities
- Residual Weakness
- Requires Assistance to ambulate
- Confusion, unable to go out of home alone
- Unable to safely leave home unassisted

- Severe SOB, SOB on exertion
- Dependent upon adaptive devices(s)
- Medical Restrictions
- Other, please specify \_\_\_\_\_

Place a check mark in appropriate box.

#### FUNCTIONAL STATUS GOALS

- Pt/CG performs ADL at max, level of independence
- Pt/CG performs procedure related to care
- Pt/CG manage equipment related to care
- Patient to achieve maximum level of:

- gait normal reciprocal pattern
- Gait on level with \_\_\_\_\_
- Gait on non-levels with \_\_\_\_\_
- Gait on Stairs
- Gait on curbs/ramp
- Transfers
  - Toilet
  - Bed
  - Chair
  - Tub

- Bed Mobility
- Decrease risk of falls

Patient to achieve maximum skills in:

- Feeding
- Homemaking
- Bathing with Equipment
- Auditory comprehension
- Safe swallowing
- Silent reading
- Writing
- Other: \_\_\_\_\_
- Pain Management
- Breathing Technique
- Vitals Management
- Caregiver competence
- Pressure Relief
- Energy Conservation
- Balance Sit or Stand
- Strength
  - UE
  - LE
  - Trunk
- Postural Alignment
- Coordination of UE Gross or fine
- Coordination of LE Gross
- Endurance for functional activities/ADL/IAL/Mobility
- W/C mobility/ safety

#### KNOWLEDGE GOALS

- Pt/CG verbalizes understanding of:
  - Home/exercise program/ activity management
  - S/S of complications
  - Other: \_\_\_\_\_
  - Mobility Techniques
  - Safety
  - Adaptive Equipment
  - Assistive device
  - Joint Protection precaution
  - Safe Swallowing
  - Auditory comprehension techniques

Pt/ CG identify necessary lifestyle changes which may improve health status (mandatory for chronic illness)

Pt/ CG identify home and environment safety measures

- Pt/ CG demonstrates compliance with:
  - Home/exercise program/ activity management
  - Appropriate response to complications
  - Other: \_\_\_\_\_
  - Mobility Techniques
  - Safety
  - Adaptive Equipment
  - Assistive device
  - Joint Protection precaution
  - Safe Swallowing
  - Auditory comprehension techniques
  - Fall risk prevention
  - Home Modifications

Therapist's Name/ Signature/ Title

Date