Family Home Health Services, Inc.
Centered Hospice • Solutions for Seniors, Inc.

Patient Name *(Print)*	
FHHS ID #	
Date:	
Time in:	Time Out:

Occupational Therapy Evaluation/Clinical Note [] Initial [] Resume [] Recert [] 30 day re-assessment

VITALS BP = ***P =*** ***R =*** ***T =***

Therapy Dx:

Current Weight Bearing Status: [] FWB []WBAT [] PWB R / L []TTWB R / L []NWB R / L

Func. Status Prior to Most Recent Illness/Injury: [] Independent [] Independent with AD *(specify AD)*:

Living conditions: [] Private home []Apartment []ILF []ALF (*state level of assistance)*:

[] Stairs to enter/exit home: []HR: []Stairs inside home: []HR

Living situation*:* [] Lives alone [] With spouse [] Caregiver assistance *(specify)*

Medical History: [] Diabetes *(Type)*: [] H/O falls []COPD []HTN [] Depression [] CHF [] A-fib [] GERD

[] OA (*specify joint/s*) [] Dementia *(specify if appropriate)* List other:

Reason(s) Homebound: [] Severe Dizziness []Confined to w/c [] Severe Anxiety [] Uncontrolled pain [] Requires use of AD

[] SOB with minimal exertion [] Difficult & taxing effort to leave home [] Unsteady Gait [] Poor Coordination

[] Dependent with ADL's [] Compromised Mental Status [] High Risk of infections [] Other

New Meds *(Started within past 30 days)* [] N/A **List:**

Pain: [] 0 ***(no pain)*** **[]1 []2*(mild)* []3 []4 *(moderate)* []5 []6 []7 *(severe)* []8 []9 []10** ***(worst pain possible)***

Location: At Rest:*(painscore)* Relieved by:

Mental Status: []Person []Place []Time []Situation [] Forgetful [] Confused [] Follows commands

Emotional Behavior Affecting Lifestyle: [] Impulsive [] Frustration [] Anxiety [] Labile [] Other:

Eyes: [] WNL [] Glasses/Contacts [] Impaired:

Ears: [] WNL [] Hearing Aid [] Impaired:

Home Assessment/Safety Awareness/Equipment: [] Current Home Equip:

Other: See attached assessment at the end of Evaluation

Caregiver available, capable, willing to assist pt: [] None *Name/Relation to pt:*

Functional Assessment Test(s) Completed: ***(at least 2)*** [] Tinetti [] Berg Balance [] TUG []Dynamic Gait Index

[] 30 sec chair rise test []Functional Reach Test []2 min step test []Other ***Score:***

Risk of fall: []Low []Moderate []High **Other** *(Explain results of test)*:

Balance (Score: Good, Fair, Poor) Sit Static: Sit Dynamic: Stand Static: Stand Dynamic:

Coordination: [] Gross WNL [] Fine WNL [] Impaired:

Sensation [] WNL [] Impaired *(incl body part tested and testing method)*

Muscle Tone: [] WNL [] Impaired:

Muscle Strength (1=Trace 2=Poor 3=Fair 4=Good 5=Normal)

Joint	Score	Joint	Score	Other joints	Score
[] Elbow ext	[]	[] Wrist flex	[]		
[] Elbow fle:	[]	[] Wrist ext	[]		

Joint	Score
[] Shoulder flex	[]
[] Shoulder ext	[]
[] Shoulder abd	[]
[] Shoulder add	[]

Endurance: [] Poor [] Fair [] Good

ROM: Shoulder [] WNL/WFL [] Impaired (graded by degree):

Elbow [] WNL/WFL [] Impaired (graded by degree): Wrist [] WNL/WFL [] Impaired (graded by degree):

(con't p. 2) ***Ther. Initials:***

Patient Name: Date:

Occupational Therapy Evaluation/Clinical Note *(con't)*

KEY: **1**=Depndnt **2**=Max. Assist **3**=Mod. Assis **4**=Min Assist **5**=Contact Guard Assist **6**= Modified Indep. **7**=Indep.

Transfers	Bedmobility:	[] Roll to: Rt	Lt	[]Supine to Sit:	[]Sit to Supine: [] Bridging
	[]Sit to stand:	[]W/C or chair to bed:			[]Bed to w/c or chair
	Tub [] With Bench	[] Without Bench:		[] Standing Shower	[] Toilet/Commode:

List Assistive device used:

ADL's	Hygiene:	Bathing:	Toil. Hyg.:	Grooming:	Safety:	Cooking:
	UE Drsg:	LE Drsg:	Cleaning:	Laundry:	Shopping:	Containers:

List Assistive device used:

Ther Exs/MS Re-ed completed

Coord:

Balance:

Exercise(list ex completed)	PROM:	AROM	AAROM	Resistance	

Functional Limits Related to injury/illness	Planned Treatment *(related to Functional Limitations)*

Anticipated Outcome/Goal

Short Term Goals: *(include end date and assist level)*	Status of Goal
1 Patient will	
2 Patient will	
3 Patient will	
4 Patient will	
Long Term Goals: *(include end date and assist level)*	**Status of Goal**
1 Patient will	
2 Patient will	
3 Patient will	
4 Patient will	

Rehab. Potential: [] Good [] Fair [] Poor ***for*** **[]** Full [] Partial ***recovery.***

Skilled Interventions/Teaching:

(con't p. 3)

Ther. Initials:

Patient Name: Date:

Occupational Therapy Evaluation/Clinical Note *(con't)*

Skilled Interventions/Teaching (*con't from p. 2* ***):***

PLAN [] Ther Ex/ROM [] Upgrade ADL [] Upgrade IADL [] Sensory Integration [] Home Exercise program

[] Task Segmentation [] Energy Conservation [] Meal Prep [] Equipment Safety Education

[] Home Safety Education []Other

Visit Freq/Dur: Total Visits:

[] Assessed need for (check all that apply) [] **RN** **[]HHA** **[]MSW** **[]ST** **[]PT**

[] DC: [] No Further need [] Patient request [] Other

Plan of Care Reviewed with Patient/Caregiver [] Instructed in benefits/risks of rehabilitation

[] Patient/Caregiver questions answered

[] Patient/Caregiver agrees with POC

Communicated to: [] MD [] RN [] Family/POA [] Other:

Communication Note:

Therapist Name, Credentials *(Print)*: Signature:

Patient Signature: Date: