OCCUPATIONAL THERAPY EVALUATION/PLAN OF CARE

REASON FOR EVALUATION: ❍ Initial Evaluation ❍ 30-Day Re-evaluation

Use this form when skilled nursing is case management. Complete all sections per agency policy.

DATE OF SERVICE:_____ **TIME IN**_____ **TIME OUT**_____

PERTINENT MEDICAL INFORMATION

Onset Date:_____ Date of Birth:_____

Therapy Primary Diagnosis:_____

List All Pertinent Diagnoses:_____

_____

Medical Precautions/Limitations: (reference OASIS)

Does the patient have a cognitive or physical impairment that effects their communication ability (include language barrier)? ❍ No ❍ Yes (explain):_____

_____

Primary method to communicate:_____

Primary language (if applicable):_____

SOC DATE: _____

❍ G0151 ❍ G0159 Maintenance

Certification Period:

_____ to _____

Physician Name: _____

Phone Number: _____

PRIORITY CODE:_____

(Coordinate with case manager)

HOMEBOUND REASON: Meets CMS Criteria Number: ❑ One ❑ Two and ❑ leaving home must require considerable and taxing effort (refer to OASIS SOC/ROC Confined to home)

(Complete per agency policy) Does the patient have an Advance Directive? ❍ Yes ❍ No Was a copy given to the agency? ❍ Yes ❍ No

Patient: ❍ Lives alone ❍ Lives with another person ❍ Lives with a group of people

Primary Caregiver(s) (if any) Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Caregiver(s) willing to assist patient? ❍ Yes ❍ No (explain):_____

Representative's Name:_____ Phone:_____ ❑ No Change ❑ Change since last eval

Abe to safely care for patient? ❍ Yes ❍ No (explain):_____

Availability of assistance: ❑ Around the clock ❑ Regular daytime ❑ Regular nighttime ❑ Occasional/short-term ❑ No assistance available

List schedule (e.g., 4 hrs AM Monday): _____ Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun

No regular schedule (explain):_____

Emergency Contact Name:_____ Relationship:_____ Phone:_____

List other available supports:_____

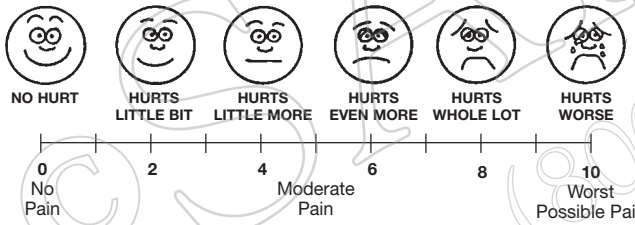
PAIN

Check box to indicate which pain assessment was used.

❍ Wong-Baker ❍ PAINAD (on next page)

Intensity: (using scales below)

Wong-Baker FACES Pain Rating Scale



Collected using: ❍ FACES Scale ❍ 0-10 Scale (subjective reporting)

**From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

VITAL SIGNS

Blood Pressure: ❑ Sitting ❑ Lying R_____ L_____

❑ Standing R_____ L_____

Temperature:_____ ❑ Oral ❑ Axillary ❑ N/A

Pulse: ❑ Apical_____ ❑ Radial_____ Rhythm: ❍ Reg ❍ Irreg

Respirations:_____ ❍ Regular ❍ Irregular

O_2 @ _____LPM via: ❑ Cannula ❑ Mask ❑ Trach

O_2 saturation _____%: ❍ At rest ❍ With activity

Impacting function? ❍ Yes ❍ No (specify):_____

_____

Mental/Cognitive Status: ❑ Oriented ❑ Disoriented ❑ Forgetful ❑ Agitated ❑ Depressed ❑ Lethargic ❑ Confused ❑ Anxious ❑ Disruptive behaviors ❑ Inattentive ❑ Disorganized thinking ❑ Vigilant ❑ Stuporous ❑ Comatose

Pain Assessment IN Advanced Dementia - PAINAD*

ITEMS	0	1	2	SCORE
Breathing Independent of Vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial Expression	Smiling, or inexpressive	Sad, Frightened, Frowning.	Facial grimacing	
Body Language	Relaxed	Tense, Distressed pacing, Fidgeting.	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
****Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain 0 = "no pain" to 10 = "severe pain").**			**TOTAL****	

Instructions: Observe the older person both at rest and during activity/with movement. For each of the items included in the PAINAD, select the score (0, 1, or 2) that reflects the current state of the person's behavior. Add the score for each item to achieve a total score. Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity. **Note:** Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and report from an individual knowledgeable of the person and their pain behaviors. Remember that some individuals may not demonstrate obvious pain behaviors or cues.

***Reference:** Warden, V, Hurley AC, Volicer, V. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *J Am Med Dir Assoc*, 4:9-15. Developed at the New England Document updated 1.10.2013.

PATIENT NAME – Last, First, Middle Initial	PHYSICIAN NAME / TITLE	ID#

SENSORY STATUS - VISION

❑ **No Problem** ❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below
❑ PERRLA

Normal: ❑ R ❑ L Partial Impaired: ❑ R ❑ L
Severely Impaired: ❑ R ❑ L
❑ Other (specify):______________________________

NOSE

❑ **No Problem**
❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

❑ Congestion ❑ Epistaxis ❑ Loss of smell ❑ Sinus problem
❑ Other (specify):______________________________

THROAT

❑ **No Problem**
❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

❑ Dysphagia ❑ Hoarseness ❑ Lesion(s) ❑ Sore throat
❑ Other (specify):______________________________

MOUTH

❑ **No Problem**
❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

❑ Dentures: ❑ Upper ❑ Lower ❑ Partial ❑ Mass(es) ❑ Tumor(s)
❑ Gingivitis ❑ Ulceration(s) ❑ Toothache ❑ Lesion(s)
❑ Other (specify):______________________________

EARS

❑ **No Problem**
❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

Hearing is adequate: ❑ R ❑ L
Mild to moderately impaired: ❑ R ❑ L Severely impaired: ❑ R ❑ L
❑ Other (specify):______________________________

ENDOCRINE/HEMATOLOGY

❑ **No Problem**
❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

Disorder(s) of endocrine system (type):______________________________

INTEGUMENTARY STATUS

❑ **No Problem**
❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

Disorder(s) of skin, hair, nails (details):______________________________

NUTRITIONAL STATUS

❑ **No Problem**
❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

❑ NAS ❑ NPO ❑ Controlled Carbohydrate
❑ Other:______________________________

Nutritional requirements (diet)
____

Appetite: ❍ Good ❍ Fair ❍ Poor ❍ NPO

Nutritional Approaches: Check all that apply
❑ Parenteral/IV feeding
❑ Feeding tube – nasogastric or abdominal (e.g. PEG, NG)
❑ Mechanically altered diet – change of texture with solids or fluids (e.g., pureed or thickened)
❑ Therapeutic diet – (e.g., low salt, low cholesterol, gluten free, diabetic)
❑ N/A

KEY: I - Intact, MIN - Minimum Impairment, MOD - Moderate Impairment, MAX - Maximum Impairment, U - Untested

I	MIN	MOD	MAX	U	Task	Comments/Assist Device
					Lip Closure	
					Ability to swallow	❑ Evaluate further
					Ability to bring food/drink to mouth	**Adaptive devices:** ❍ Used ❍ Not used

ELIMINATION STATUS

❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

Urinary Elimination: ❑ **No Problem**
Disorder(s) of urinary system (type):______________________________

Bowel Elimination: ❑ **No Problem**
Disorder(s) of GI system (type):______________________________

ABDOMEN

❑ **No Problem**
❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

❑ Tenderness ❑ Pain ❑ Distention ❑ Hard ❑ Soft ❑ Ascites
❑ Abdominal girth ________ cm
❑ Other:______________________________

GENITALIA

❑ **No Problem**
❑ 30-Day Evaluation ❑ No Changes
❑ Change(s) identified this visit documented below

Comments:______________________________

PATIENT NAME – Last, First, Middle Initial	PHYSICIAN NAME/TITLE	ID#

NEURO / EMOTIONAL / BEHAVIORAL STATUS

❑ **No Problem**

❑ 30-Day Evaluation ❑ No Changes

❑ Change(s) identified this visit documented below

Comments:_____

MUSCULOSKELETAL

❑ **No Problem**

❑ 30-Day Evaluation ❑ No Changes

❑ Change(s) identified this visit documented below

Disorder(s) of musculoskeletal system (type):_____

FUNCTIONAL LIMITATIONS

❑ Amputation
❑ Bowel/Bladder (Incontinence)
❑ Contracture
❑ Hearing
❑ Paralysis
❑ Endurance
❑ Ambulation
❑ Speech
❑ Vision
❑ Legally blind
❑ Dyspnea with minimal exertion
❑ Other (specify):_____

❑ Other (specify):_____

ADL/IADLs

❑ **No Problem**

❑ 30-Day Evaluation ❑ No Changes

❑ Change(s) identified this visit documented below

Examples of ADLs/IADLs, transfer/ambulation, bathing, dressing, toileting, eating/feeding, meal preparation, housekeeping, laundry, telephone, shopping and finances.

Independent with _____

Needs minimal help with _____

Needs moderate help with _____

Needs maximum help with _____

The patient receives assistance from a caregiver to complete the following activities: ❑ Hygiene ❑ Dressing ❑ Toileting ❑ Transfers ❑ Meal Preparation ❑ Medication Administration ❑ IADL ❑ Medical Treatments ❑ Equipment Management ❑ Supervision and Safety

❑ Safety measures to protect against injury: _____

❑ Additional Information:_____

ACTIVITIES PERMITTED

❑ Complete bedrest
❑ Bathroom privileges
❑ Up as tolerated
❑ Transfer bed/chair
❑ Exercises prescribed
❑ Partial weight bearing
❑ Independent in home
❑ Crutches
❑ Cane
❑ Wheelchair
❑ Walker
❑ No restrictions
❑ Other (specify):_____

❑ Other (specify):_____

❑ Other (specify):_____

MEDICATIONS/TREATMENTS

Medication and/or treatments (collect information per agency policy):

DME / MEDICAL SUPPLIES

DME Company:_____

Phone:_____

Oxygen Company:_____

Phone:_____

❑ Community Organizations ❑ Services:_____

List DME/Medical Supplies/Assistive Devices:_____

REFUSED CARES

Did the ❑ Patient ❑ Representative ❑ Other:_____ refuse ❑ care(s) ❑ service(s) in advance? ❍ No ❍ Yes

If yes, explain:_____

Could the ❑ care(s) ❑ service(s) they refused significantly affect the recommended plan of care? ❍ No ❍ Yes

If yes, explain how:_____

PATIENT NAME – Last, First, Middle Initial	PHYSICIAN NAME / TITLE	ID#

EMERGENCY PREPAREDNESS CARE PLANNING

Complete this section per agency policy for applicable activities completed during this visit and coordinate with case management.
(check all that apply)

❑ Change(s) identified this visit documented below

❑ Emergency Priority Code assigned to this patient is _____

(**Note**: Record the code on the front page of this form and other places per agency policy)

❑ Obtained the patient's emergency contact number(s) for the medical record

❑ Discussed the therapy service plans for supporting their patients during a natural or man-made disaster

❑ Discussed patient specific emergency planning options

❑ Discussed the development of the patient's individualized emergency preparedness plan of care, including self-care readiness and the procedure to follow up with the HHA in the event services are interrupted

❑ Written materials to restate/reinforce the emergency preparedness procedures given to the ❑ Patient ❑ Representative (if any)

❑ Caregiver ❑ Other:_____

Comments: _____

MUSCLE STRENGTH/ROM EVAL

	AREA	STRENGTH Right	STRENGTH Left	ACTION	ROM Right Active	ROM Right Passive	ROM Left Active	ROM Left Passive
UPPER EXTREM.	Shoulder			Flex/Extend				
				Abd./Add.				
				Int. Rot./Ext. Rot.				
	Elbow			Flex/Extend				
	Forearm			Sup./Pron.				
	Wrist			Flex/Extend				
	Fingers			Flex/Extend				
LOWER EXTREM.	Hip			Flex/Extend				
				Abd./Add.				
				Int. Rot./Ext. Rot.				
	Knee			Flex/Extend				
	Ankle			Plant./Dors.				
	Foot			Inver./Ever.				

SPINE	AREA	STRENGTH	ACTION	ROM

MANUAL MUSCLE TEST (MMT) 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	Trace strength - slight muscle contraction - no motion
0	Zero - no active muscle contraction

ADL/IADLs

Check appropriate responses. KEY: I - Independent, VC/SBA - Verbal Cues/Stand-by Assist, MIN - Minimum Assist, MOD - Moderate Assist, MAX - Maximum Assist, D - Totally Dependent

I	VC/SBA	MIN	MOD	MAX	D	Task	Comments/Assist Device
						Clothing Management	
						Toilet Hygiene	

Toileting Assessment:
Previous level:_____
Current level:_____

I	VC/SBA	MIN	MOD	MAX	D	Task	Comments/Assist Device
						Transfers: Bed	
						Wheelchair	
						Toilet	
						Tub/Shower	
						Car	
						Bed Mobility: Roll/Turn	
						Sit/Supine	
						Sit/Stand	

Transfer Assessment:
Previous level:_____
Current level:_____
❑ Appears Functional ❑ Additional Training Required

I	VC/SBA	MIN	MOD	MAX	D	Task	Comments/Assist Device
						Comb Hair	For testing patient/client: ❑ Standing ❑ Sitting, surfaces_____
						Shaving/Make-up	
						Oral Hygiene	❑ Teeth ❑ Dentures: ❑ Upper ❑ Lower ❑ Partial
						Fingernail Care	
						Wash Face/Hands	

Additional ADL Comments:
_____

CURRENT FINDINGS/GAIT EVALUATION

Muscle Tone: _____

Posture: _____

Endurance: _____

PATIENT NAME – Last, First, Middle Initial	PHYSICIAN NAME/TITLE	ID#

CURRENT FINDINGS/GAIT EVALUATION (Cont'd)

Gait Assessment:	Level Surfaces	Uneven Surfaces	Stairs	Other
Distance				
Assistance				
Assistive Device				
Quality/Deviations				

Weight Bearing Status: (specify extremities)_____

❑ FWB ❑ WBAT ❑ PWB ❑ TDWB ❑ NWB

Assistive Device(s): ❑ Cane ❑ Quad Cane ❑ Hemi Walker ❑ Walker ❑ Wheeled Walker ❑ Other:_____

Comments:_____

(Check all applicable items)

Sitting Static ❍ Good ❍ Fair ❍ Poor
Sitting Dynamic ❍ Good ❍ Fair ❍ Poor
Standing Static ❍ Good ❍ Fair ❍ Poor
Standing Dynamic ❍ Good ❍ Fair ❍ Poor

Standardized Balance Assessment Used and Results:

Tinetti:_____ BERG:_____ Timed Up and GO:_____

Other:_____

MOTOR COMPONENTS

Tonicity: ❑ WNL ❑ Hypertonic ❑ Hypotonic

Describe:_____

I	MIN	MOD	MAX	U		Comments
					Fine Motor Coordination Left	
					Right	
					Gross Motor Coordination Left	
					Right	

SENSORY/PERCEPTUAL MOTOR SKILLS

KEY: I – Intact, MIN – Minimal Impairment, MOD – Moderate Impairment, MAX - Maximum Impairment, U - Untested

Area	Sensory Testing		Perceptual Testing	
	RIGHT	LEFT	RIGHT	LEFT

Visual Tracking:_____

R/L Discrimination:_____

Motor Planning Praxis:_____

Do sensory/perceptual impairments affect safety? ❍ Yes ❍ No

If Yes, recommendations:_____

Comments/Other Impairments Noted:_____

FALL RISK ASSESSMENT

MAHC 10 - FALL RISK ASSESSMENT TOOL

REQUIRED CORE ELEMENTS **Assess one point for each core element "yes".** *Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.*	Points
Age 65+	
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis.	
Prior history of falls within 3 months A unintentional change in position resulting in coming to rest on the ground or at a lower level.	
Incontinence Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.	
Visual impairment Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	
Impaired functional mobility May include patients who need help with IADLs or ADLs or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	

	Points
Environmental hazards May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	
Poly Pharmacy (4 or more prescriptions – any type) All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patient's ability to adhere to the plan of care.	
A score of 4 or more is considered at risk for falling **TOTAL**	

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PATIENT NAME – Last, First, Middle Initial	PHYSICIAN NAME / TITLE	ID#

List other validated tools used to complete this evaluation and the score obtained for example; physical, psychosocial or cognitive assessment:

❑ Patient ❑ caregiver ❑ family ❑ representative were present during evaluation. ❑ Patient ❑ caregiver ❑ family ❑ representative actively participated with the therapy plan of care to facilitate future discharge? ❍ Yes ❍ No (comment):

When the ❑ patient ❑ caregiver ❑ family ❑ representative was asked to state their specific goal(s) from the therapy service they stated:

List any care preferences stated by the ❑ patient ❑ caregiver ❑ family ❑ representative (include refusal of cares):

Assess the patient's psychosocial status (refers to mental health, social status, and functional capacity) within the community (e.g., education and marital history etc.). Include barriers to care and possible referral(s) for other care services and/or outside entities.

Assess the patient's cognitive ability (ability to understand, remember, and participate in developing and implementing the plan of care).
(Note: CMS is not requiring the use of any particular tool, nor are they prescribing the extent of the cognitive status assessment.)

List the patient's strengths that will help them to meet their realistic functional goal(s) (for example physical, psychosocial, cognitive ability [such as motivation] and support system):

❑ Education ❑ Training that was ❑ needed ❑ received during this visit (explain):

❑ Patient ❑ caregiver ❑ family ❑ representative response to today's visit:

SIGNATURE/DATE

Signature and Title of Person
Who Completed Evaluation: _____ Date: _____

PATIENT NAME – Last, First, Middle Initial	PHYSICIAN NAME / TITLE	ID#

List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit (M1033, M1034 and M1036).

RISK FACTORS/HOSPITAL ADMISSION/EMERGENCY ROOM

Risk factors identified and followed up on by: ❑ Discussion ❑ Education ❑ Training

Literature given to: ❑ Patient ❑ Representative ❑ Caregiver ❑ Family Member ❑ Other:_____

List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit (M1034 and M1036).

_____

_____

_____

❑ N/A

Note: *Following a patient's hospital discharge, HHA are required by CMS to include an assessment of the patient's level of risk for hospital ED visits and hospital admission. Interventions are required in the patient's plan of care. When assessing the patient, pay particular attention to patients with CHF, AMI, COPD, CABG, pneumonia, diabetes or hip and knee replacements. Consider these factors co-morbidities, multiple medications, low health literacy level, history of falls, low socioeconomic level, dyspnea, safety, confusion, chronic wounds, depression, lives alone, support system, etc.*

REHABILITATION POTENTIAL FOR ANTICIPATED DISCHARGE PLANNING

❍ Return to an independent level of care (self-care)

❍ Able to remain in residence with assistance of: ❑ Primary Caregiver ❑ Support from community agencies

❍ Restorative Potential, based on clinical objective assessment and evidence based knowledge the patient's condition is likely to undergo functional improvement and benefit from rehabilitative care

❑ Discussed discharge plan with: ❑ Patient ❑ Representative ❑ Other:_____

❑ Intermittent therapy services are reasonable and necessary to continue based on the evaluation finding. See Summary below.

Estimated duration of continued services for this patient is _____, and anticipated discharge date is _____.

Prognosis:_____

Rehabilitation Potential:_____

SUMMARY CHECKLIST

CARE PLAN: Collaboration with: ❑ Patient ❑ Caregiver ❑ Representative ❑ Family involvement

MEDICATION STATUS: ❑ Medication regimen completed ❍ No change ❍ Order obtained

Therapy only case: List of medications submitted to HHA RN for drug regimen review? ❍ No ❍ Yes

If yes, name of RN who reviewed medications and contacted physician, if indicated:_____

Check if any of the following were identified:

❑ Potential adverse effects ❑ Drug reactions ❑ Ineffective drug therapy ❑ Significant side effects

❑ Significant drug interactions ❑ Duplicate drug therapy ❑ Non-compliance with drug therapy

CARE COORDINATION: ❑ Certifying Physician ❑ PT ❑ OT ❑ SLP ❑ MSW ❑ Aide ❑ Other (specify):_____

Was a referral made to MSW for assistance with: ❑ Community resources ❑ Living will ❑ Counseling needs ❑ Unsafe environment

❑ Other:_____

Date:_____ ❍ Yes ❍ No ❍ Refused ❍ N/A

Summary:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Verbal Order obtained: ❍ No ❍ Yes, specify date:_____

SIGNATURE/DATE

X _____ _____ _____

Person Completing This Form (signature/title) *Date* *Time*

_____ _____

Agency Name *Phone Number*

PATIENT NAME – Last, First, Middle Initial	PHYSICIAN NAME/TITLE	ID#

INSTRUCTIONS
FOR COMPLETING CARE PLAN PAGES

Complete frequency and duration then develop plan of care.

Guidelines for Goal Statement:

Goal template: ***Who*** The __ patient ___ caregiver will ___ **increase** ___ **improve** ___ **maintain**; ***what*** (identified deficit, need or functional limitation): ***amount of measurable change/objective measure*** (from baseline score/measurement, with a device or human assistance if needed, to reach a specific goal with a device or human assistance, if needed; objective measurement can be a validated assessment score or other measurement methods): ***why/functional relevance*** (related to patient's clinical need and the patient's personal goal): ***when/time frame projection*** (within ___ days ___ weeks or by a specific date): indicate short or long term goal: **to facilitate the patient's discharge.**

Short term goal (STG) or long term goal (LTG). See examples below.

#1. *Patient* will *improve right shoulder ROM* ***from*** *90 degrees* ***to*** *135 degrees* in *6 weeks (LTG), to be able to comb*
Who improve what amount of measure *from - to* when LTG why/functional

her hair, to facilitate discharge/referral.
relevance planning for discharge/referral

#2. *Patient* will *increase hip extensor strength* ***from*** *3+/5* ***to*** *4/5* in *3 weeks (STG), to allow sit to stand transfer on*
Who increase what amount of measure *from - to* when STG why/functional relevance

1st attempt, to facilitate discharge/referral.
planning for discharge/referral

#3. *Patient* will *increase distance ambulated* ***from*** *20 feet* ***to*** *40 feet with front wheel walker* in *two 2 weeks (STG)*
Who increase what amount of measure from – to with a device when STG

to allow ability to walk from bedroom to bathroom safely with standby assist, to *facilitate discharge/referral*
why/functional relevance planning for discharge/referral

The purpose of this Therapy Care Plan is to add new goals to the current plan of care when the nursing clinical manager is responsible for case management. Goals can be short or long term.

Guidelines for filling out the Plan of Care pages:

- Fill-in ***Certification Date*** in top right corner of form.
- Fill-in ***Today's Date*** in top left corner of form.
- Write in ***Frequency and Duration***.
- Assign a number to each goal that is written. Write the goal number in the box labeled ***Goal #***.
- Write the date the goal will start in the column labeled ***Start Date***.
- When a goal is completed/met put the date in the column labeled ***Date Completed/Met***.
- Write the expected discharge date in the column labeled ***Date of Expected Discharge***.
- If applicable, write the date that a goal changes in the column labeled ***Date Goal Changed/Updated***.

	IDENTIFIED NEED/IMPAIRMENT (based on evaluation) **EXPECTED PATIENT OUTCOME/GOAL(S) SHORT (STG) AND LONG TERM (LTG) GOAL** (must be objective and measurable) *(Patient will...)*	**THERAPY INTERVENTION/ ACTION** *(Therapy will...)*	**EVALUATION**	
GOAL # 1 **Start Date**	**Date Goal Changed/ Updated**		**Date Completed/ Met**	**Date of Expected Discharge**
3/1/2018		Patient will increase distance ambulated from 20 feet to 40 feet with front wheel walker in two 2 weeks (STG) to allow ability to walk from bedroom to bathroom safely with stand-by assist, to facilitate discharge/referral.	3/14/2018	
	3/14/2018	Patient will increase distance ambulated 40 feet without walker in two 2 weeks (STG) to allow ability to walk from bedroom to bathroom safely with standby assist, to facilitate discharge/referral.	3/28/2018	3/28/2018

Write one goal per box of the care plan. Do not change the goal numbers. For example, goal #1 will always be goal #1. If goal #1 is changed/updated continue to call it goal #1. See example directly above.

Use this form when nursing provides case management. The information will be added to the plan of care and sent to the physician to be signed.

If you need more space or new goal boxes, use Therapy Care Plan Addendum (Briggs form 3502P).

OCCUPATIONAL THERAPY CARE PLAN

Today's Date: _____ **CERTIFICATION DATE:** _____ to _____

Complete section below based on findings of comprehensive evaluation.
Note: some information below may be duplicated on other documents, for example comprehensive OASIS assessment.

All pertinent diagnoses (include ICD codes):_____

_____

Prognosis:_____ Advance Directives: ❍ Yes ❍ No

Rehabilitative potential:_____

Patient's mental, psychosocial and cognitive status:_____

_____

_____

_____

_____

_____

_____

Types of services/supplies and equipment required:_____

_____

_____

_____

Nutritional/diet requirements:_____

_____

Functional limitations:_____

_____

_____

_____

Activities permitted:_____

_____

_____

Safety measures to protect against injury:_____

_____

_____

_____

❑ Education ❑ Training needed:_____

Medication list and treatment list (included per agency policy) ❍ Yes ❍ No ❍ N/A (explain):_____

_____

If patient post hospitalization at the time of home health admission, list appropriate interventions necessary to address and mitigate identified risk factors for re-hospitalization and/or ED visits (this can be specific to disease process):_____

_____

_____

_____

_____

_____

_____

_____

SIGNATURE/DATE

Clinician Print Name/Title	Clinician Signature/Title	Date	Time

PATIENT NAME – Last, First, Middle Initial	PHYSICIAN NAME / TITLE	ID#

OCCUPATIONAL THERAPY CARE PLAN

Today's Date: _____ **CERTIFICATION DATE:** _____ to _____

Frequency and Duration: _____

	IDENTIFIED NEED/IMPAIRMENT (based on evaluation) **EXPECTED PATIENT OUTCOME/GOAL(S)** **SHORT (STG) AND LONG TERM (LTG) GOAL** (must be objective and measurable) *(Patient will...)*		**THERAPY INTERVENTION/ ACTION** *(Therapy will...)*	**EVALUATION**	
GOAL # _____ **Start Date**	**Date Goal Changed/ Updated**			**Date Completed/ Met**	**Date of Expected Discharge**
GOAL # _____					
GOAL # _____					

SIGNATURE/DATE

Clinician Print Name/Title | Clinician Signature/Title | Date | Time

❑ Verbal orders read back (if applicable)

PATIENT NAME – Last, First, Middle Initial	PHYSICIAN NAME / TITLE	ID#