OCCUPATIONAL THERAPY EVALUATION

❍ Initial Evaluation
❍ Re-Evaluation (Type)_____

❍ Q5001: Hospice or Home Health Care provided in patient's home/residence
❍ Q5002: Hospice or Home Health Care provided in Assisted Living Facility
❍ Q5009: Hospice or Home Health Care provided in place not otherwise specified

DATE OF SERVICE _____
TIME IN_____ **TIME OUT**_____

HOMEBOUND 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 upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions
❑ Other (specify)_____

SOC DATE_____
❍ G0152 ❍ G0160 Maintenance

PERTINENT MEDICAL INFORMATION

Onset Date:_____ **Primary Diagnosis:**_____
Medical Precautions/Limitations:_____

Vital Signs: Temp:_____ Pulse:_____ ❍ Regular ❍ Irregular
Resp.:_____ B/P:_____ Using O_2 at _____LPM via:_____

Pain:
Rating scale: 0 1 2 3 4 5 6 7 8 9 10 Current pain level:_____
No pain Mod pain Worst pain **(subjective reporting)**
Pain quality:_____ Pain location:_____
(ache, sharp, dull, etc.)
Frequency: ❍ Occasionally ❍ Continuous ❍ Intermittent ❍ Other_____
What makes pain worse? ❑ Movement ❑ Ambulation ❑ Immobility
Referral needed? ❍ Yes ❍ No Referred to:_____
Impacting function? ❍ Yes ❍ No (specify)_____
POC Goal Needed? ❍ Yes ❍ No

PERTINENT BACKGROUND INFORMATION

Prior Level of Functioning With ADLs:
❍ Independent ❍ Needed assist ❍ Total assist
History of Falls:
❍ Yes ❍ No If yes, date of last fall:_____
Intervention in place? ❍ Yes ❍ No
If 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: ❍ Yes ❍ No
(type)_____
Other:_____

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		Proprioception	
	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
Impacting Function? ❍ Yes ❍ No (specify)_____
Referral Needed? ❍ Yes ❍ No Who contacted?_____
POC Goal Needed? ❍ Yes ❍ No

COGNITIVE STATUS/COMPREHENSION

ORIENTED: ❑ Person ❑ Place ❑ Time ❑ Reason for Therapy_____

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

Impacting function? ❍ Yes ❍ No (specify)_____ **POC Goal Needed? ❍ Yes ❍ No**

MOTOR COMPONENTS (Enter Appropriate Response)

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

❍ Right handed ❍ Left handed
❑ Orthosis ❑ Used ❑ Needed (specify)_____
Impacting function? ❍ Yes ❍ No (specify)_____ **POC Goal Needed? ❍ Yes ❍ No**

PATIENT NAME – Last, First, Middle Initial | ID#

STRENGTH/ROM/TONE/EDEMA (Enter Appropriate Response)

Extremity	Strength (MMT)		AROM Measure		PROM Measure	
	Right	Left	Right	Left	Right	Left
Shoulder Flexion						
Shoulder Abduction						
Shoulder Adduction						
Elbow Flexion						
Elbow Extension						
Wrist Flexion						
Wrist Extension						
Supination						
Pronation						
Finger MCP's						

Tone: ❍ Normal ❍ Abnormal (specify):_____

Edema: ❍ Normal ❍ Abnormal (specify):_____

Impacting function? ❍ Yes ❍ No (specify)_____ **POC Goal Needed? ❍ Yes ❍ No**

OBJECTIVE DATA TESTS AND SCALES

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.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	100% active functional motion.
4	75% active functional motion.
3	50% active functional motion.
2	25% active functional motion.
1	Less than 25%.

FUNCTIONAL INDEPENDENCE SCALE (For Balance/Mobility, Self Care/ADL Skills, IADL Skills)

GRADE	DESCRIPTION
7	Independent.
6	Modified independent - verbal cues, extra time.
5	Stand-by assist (SBA) - 100% effort w/supervision.
4	Minimal assist - 75% effort.
3	Moderate assist - 25-50% effort.
2	Maximum assist - 25% effort.
1	Dependent/unable to do task <25% effort.

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
FUNCTIONAL MOBILITY/BALANCE EVALUATION					
BED MOBILITY			DYNAMIC SITTING BALANCE		
BED/WHEELCHAIR TRANSFER			STATIC SITTING BALANCE		
TOILET TRANSFER			STATIC STANDING BALANCE		
TUB/SHOWER TRANSFER			DYNAMIC STANDING BALANCE		

Impacting function? ❍ Yes ❍ No (specify)_____ **POC Goal Needed? ❍ Yes ❍ No**

SELF CARE SKILLS/ADL SKILLS					
SELF FEEDING			UB BATHING		
SWALLOWING			LB BATHING		
ORAL HYGIENE			UB DRESSING		
GROOMING			LB DRESSING		
TOILETING			FASTENERS		

Adaptive devices in place? ❍ Yes ❍ No (specify)_____

Impacting function? ❍ Yes ❍ No (specify)_____ **POC Goal Needed? ❍ Yes ❍ No**

INSTRUMENTAL ADL'S					
HOUSEKEEPING			TELEPHONE USE		
MEAL PREPARATION			MONEY MANAGEMENT		
LAUNDRY			MEDICATION MANAGEMENT		

Impacting function? ❍ Yes ❍ No (specify)_____ **POC Goal Needed? ❍ Yes ❍ No**

SUMMARY

Was a standardized/validated assessment used? ❍ Yes ❍ No If yes (specify assessment):_____

Results:_____

❑ Orders for OT evaluation only. Additional services needed: ❍ Yes ❍ No

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

Other disciplines providing care: ❑ SN ❑ PT ❑ ST ❑ MSW ❑ 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 ❑ IADLs ❑ Safety issues ❑ Other:_____
❍ Yes ❍ No If Yes: (specify) _____

❑ Referral recommendations: (specify)_____

Comments:_____

APPROXIMATE NEXT VISIT DATE:_____

PLAN FOR NEXT VISIT: _____

DISCHARGE PLAN DISCUSSED WITH: ❑ Patient/Family
❑ Care Manager ❑ Physician ❑ Other:_____

BILLABLE SUPPLIES: ❍ N/A ❍ Yes (specify)_____

CARE COORDINATION: ❑ Physician ❑ Nursing ❑ PT ❑ OT
❑ ST ❑ MSW ❑ Aide ❑ Other:_____

SUPERVISORY VISIT (Complete if applicable)

❍ OT Assistant ❍ Aide / ❍ Present ❍ Not present
Supervisory Visit: ❍ Scheduled ❍ Unscheduled
Observation of:_____

Teaching/Training of:_____
Signature/Title:_____
Next Scheduled Supervisory Visit:_____
Care plan reviewed/revised with assistant/aide during this visit:
❍ Yes ❍ No If yes (specify)_____

If OT assistant/aide not present, specify date he/she was contacted regarding updated care plan:_____

SIGNATURES/DATES

Complete **TIME OUT** (on first page) prior to signing below.

X _____ _____
Patient/Caregiver (if applicable) *Date*

_____ _____
Therapist (signature/title) *Date*