# THERAPEUTIC RECREATION/ACTIVITY EVALUATION

- □ New Admission  
- □ Annual  
- □ Significant Change of Condition

## PERSONAL STRENGTHS

- □ Motivated  
- □ Cooperative  
- □ Adapts to change  
- □ Cheerful  
- □ Leisure interests  
- □ Independent  
- □ Able to make needs known  
- □ Feels useful  
- □ Developed coping skills  
- □ Sense of humor  
- □ Decisive  
- □ Other: ________________________________

## SOCIAL SUPPORT SYSTEMS

**A. PRIMARY VISITORS**

- □ Family  
- □ Friend / Peer  
- □ Volunteer:  
  - □ Community  
  - □ Facility  
- □ Religious  
- □ Pet  
- □ No visitors  
- □ Other ________________

**B. TYPES OF CONTACT**

- □ Visits  
- □ Telephone  
- □ Mail  
- □ Outings  
- □ Other ____________________________

**C. HELPS OTHERS**

- □ Volunteer:  
  - □ Community  
  - □ Facility  
- □ Therapeutic Work  
- □ Friendly visitor  
- □ Activity leader  
- □ Other  
- □ No interest

## RECREATION INTERESTS/NEEDS

**A. ACTIVITY ENVIRONMENT**

- □ Groups:  
  - □ Large  
  - □ Small  
  - □ Special Needs  
- □ Independent (self-directed)  
- □ One-to-one  
- □ Community  
- □ Own room  
- □ Day/Activities room  
- □ Inside facility/off unit  
- □ Indoor  
- □ Outdoor  
- □ Other  
- □ No Interest

**B. PARTICIPATION IN ACTIVITIES**

- □ Active participation  
- □ Passive participation  
- □ Independent/Individual  
- □ Leadership exhibited  
- □ Encouragement needed  
- □ No Interest

**C. ACTIVITY SCHEDULE PREFERENCE**

- □ Morning  
- □ Afternoon  
- □ Evening  
- □ None of these, (explain) ________________________________

## PURSUIT PATTERNS

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**NAME**—Last First Middle

Attending Physician  
Record No.  
Room/Bed
## ADAPTATIONS FOR ACTIVITY PARTICIPATION OR SKILLS FOR PERSONAL GROWTH

### A. SENSORY:
- ☐ Hearing
- ☐ Vision
- ☐ Taste
- ☐ Touch
- ☐ Smell

☐ Needs assistance  ☐ Needs reminder
☐ Needs adapted activity. Specify: ________________________
☐ Needs adaptive equipment. Specify: ____________________

### B. COGNITIVE:
- ☐ Requires reminders/cues
- ☐ Requires extensive verbal cuing
- ☐ Cannot comprehend instructions

☐ Needs adapted activity. Specify: ________________________
☐ Needs adaptive equipment. Specify: ____________________

### C. PHYSICAL:
- ☐ Assistance needed getting to and from activity areas: ☐ W/C  ☐ G/C  ☐ Walker  ☐ Other _____________

☐ Needs adapted activity. Specify: ________________________
☐ Needs adaptive equipment. Specify: ____________________

### D. BEHAVIORAL:
- ☐ Needs encouragement
- ☐ Needs re-direction
- ☐ Needs reminders

☐ Needs adapted activity. Specify: ________________________
☐ Needs adaptive equipment. Specify: ____________________

### E. COMMUNICATION:
- ☐ Primary language, other than English: ________________________
- ☐ Cannot initiate conversation
- ☐ Non-verbal
- ☐ Gestures
- ☐ Other ________________________

☐ Needs adapted activity. Specify: ________________________
☐ Needs adaptive equipment. Specify: ____________________

## SPECIAL PRECAUTIONS/CONSIDERATIONS

Comments: ____________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

## ACTIVITY CARE PLAN DECISION

☐ Proceed (explain why activity CP is required)
☐ Not Proceed (explain why activity CP not required)

Comments: ____________________________________________
________________________________________________________________________
________________________________________________________________________

## SOURCES OF INFORMATION FOR ASSESSMENT

- ☐ MDS/CAAs/other assessments
- ☐ Progress notes
- ☐ Staff interview
- ☐ Care plans
- ☐ Resident interview
- ☐ Physician consultation
- ☐ Resident observation
- ☐ Family interview
- ☐ Other/identify ________________________

Signature/Title: ________________________ Date: ________________________

NAME–Last First Middle Attending Physician

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