Occupational Therapy Evaluation

Patient Last Name, First Name, M.I.	Patient #	HIC #

Reason for Referral:

Precautions:

Level of Assistance: Independent=I; Modified Independent=M; Stand By Assist=SBA; Supervision=S; Contact Guard Assis=CGA; Minimum=Min; Moderate=Mod; Maximum=Max; Dependent=D

Activities of Daily Living (MDS G-1g,h,j,2)	**Level of Assist**.	**Comments**
Feeding		
Grooming		
UB Bath		
LB Bath		
UB Dressing		
LB Dressing		
Toileting/Hygiene		
Homemaking Skills		
Functional Mobility (MDS G-1a,b, I)	**Level of Assist**.	
Rolling		
Supine to Sit		
Sit to Supine		
Bed to W/C		
Toilet		
Tub/Shower		

Adaptive Equipment/Positioning:

Current Seating

	Yes	No
W/C		
Geri Chair		
Other		
Appropriate?		
Further assessment		

Other:

Balance (MDS G-3)	**Static**	**Dynamic**
Sitting		
Standing		

Activity Tolerance:

ROM and Strength/Voluntary Movement (MDS G-4: A/B)

Left					**Body Part Upper**	**Right**				
Coordination	Tone	Strength	AROM	PROM		Coordination	Tone	Strength	AROM	PROM
					Shoulder					
					Elbow					
					Wrist					
					Hand					

Left Upper Extremity Comments:

Right Upper Extremity Comments:

Sensory Integration

Key: I=Intact; Imp=Impaired; A=Absent; NT=Not Tested					
Sensation	L	R	Perception	L	R
Stereognosis			Visual Field		
Proprioception			Figure-Ground		
Sharp/Dull			Body Scheme		
Light Touch			R/L Discrimination		
Temperature			R/L Neglect		
Pain:					

Cognitive Function

Orientation:	Person	Place	Time
Follows Commands:	One-Step	Multi-Step	Unable
Communication:	Verbal	Non-verbal	None
Attention Span:			
Judgment:			
Memory:			
Safety Awareness:			
Comments:			

Assessment:

Therapist Signature/Credentials/Date: _____

Physician's Name: _____ **Patient's Room #** _____