OT Evaluation

Clinician:

Patient Name (Last Name, First Name) & MRN:	Mileage:	Gender: ☐ M ☐ F	Agency Name/Branch:

Date: / /	Time In: Time Out:	DOB: / /

HCPCS

Select the home health service type that reflects the primary reason for this visit:

- ☐ (G0152) Services Performed by a qualified occupational therapist
- ☐ (G0158) Services performed by a qualified occupational therapist assistant
- ☐ (G0160) Establishment or delivery of a safe and effective occupational therapy maintenance program

Select the location where home health services were provided:

- ☐ (Q5001) Care provided in patient's home/residence
- ☐ (Q5002) Care provided in assisted living facility
- ☐ (Q5009) Care provided in place not otherwise specified (NO)

Diagnosis / History

Medical Diagnosis: ☐ Exacerbation ☐ Onset / /

OT Diagnosis: ☐ Exacerbation ☐ Onset / /

Relevant Medical History:

Prior Level of Functioning:

Patient's Goals:

Precautions:

Homebound? O Yes O No

- ☐ Residual Weakness
- ☐ Needs assistance for all activities
- ☐ Requires max assistance / taxing effort to leave home
- ☐ Unable to safely leave home unattended
- ☐ Severe SOB or SOB upon exertion
- ☐ Confusion, unsafe to go out of home alone
- ☐ Other:

OT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /

Social Supports / Safety Hazards

Patient Living Situation and Availability of Assistance

Patient lives: ☐ Alone ☐ With other person(s) in the home ☐ In congregate situation, e.g., assisted living

Assistance is available: ☐ Around the clock ☐ Regular Daytime ☐ Regular nighttime ☐ No assistance available ☐ Occasional / short-term assistance

Current Types of Assistance Received (other than home health staff**)**

Safety / Sanitation Hazards

☐ No hazards indentified ☐ No running water, plumbing ☐ No gas / electric appliance
☐ Steps / Stairs: ☐ Lack of fire safety devices ☐ Pets
☐ Narrow or obstructed walkway ☐ Inadequate lighting, heating and /or cooling. ☐ Unsecured floor coverings
☐ Cluttered / soiled living area ☐ Insect / rodent infestation

Other**:**

Evaluation of Living Situation, Supports, and Hazards:

Vital Signs

BP: (Prior)	*Position*	*Side*	Heart Rate:	Respirations:
Prior /	☐ Lying ☐ Sitting ☐ Standing	☐ Left ☐ Right	Prior	Prior

O_2 Saturation: Prior

Room Air / Rate

☐ Room Air ☐ 02 @ 0.5 lpm ☐ 02 @ 1.0 lpm ☐ 02 @ 1.5 lpm ☐ 02 @ 2.0 lpm
☐ 02 @ 2.5 lpm ☐ 02 @ 3.0 lpm ☐ 02 @ 3.5 lpm ☐ 02 @ 4.0 lpm ☐ 02 @ 4.5 lpm ☐ 02 @ 5.0 lpm
☐ 02 @ 6.0 lpm ☐ 02 @ 7.0 lpm ☐ 02 @ 8.0 lpm ☐ 02 @ 9.0 lpm ☐ 02 @ 10.0 lpm ☐ 02 @ 11.0 lpm
☐ 02 @ 12.0 lpm ☐ 02 @ 13.0 lpm ☐ 02 @ 14.0 lpm ☐ 02 @ 15.0 lpm ☐ Other: see Comments

Route

via ☐ NC
via ☐ Mask
via ☐ Trach
via ☐ Other: see Comments

BP: (Post)	*Position*	*Side*	Heart Rate:	Respirations:
Post /	☐ Lying ☐ Sitting ☐ Standing	☐ Left ☐ Right	Post	Post

OT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /

O_2 Saturation: Post	*Room Air / Rate*				Route
	☐ Room Air	☐ 02 @ 2.5 lpm	☐ 02 @ 6.0 lpm	☐ 02 @ 12.0 lpm	via ☐ NC
	☐ 02 @ 0.5 lpm	☐ 02 @ 3.0 lpm	☐ 02 @ 7.0 lpm	☐ 02 @ 13.0 lpm	via ☐ Mask
	☐ 02 @ 1.0 lpm	☐ 02 @ 3.5 lpm	☐ 02 @ 8.0 lpm	☐ 02 @ 14.0 lpm	via ☐ Trach
	☐ 02 @ 1.5 lpm	☐ 02 @ 4.0 lpm	☐ 02 @ 9.0 lpm	☐ 02 @ 15.0 lpm	via ☐ Other: see Comments
	☐ 02 @ 2.0 lpm	☐ 02 @ 4.5 lpm	☐ 02 @ 10.0 lpm	☐ Other: see Comments	
		☐ 02 @ 5.0 lpm	☐ 02 @ 11.0 lpm		

Comments:

Physical Assessment

Speech: ☐ WNL ☐ Impaired

Vision: ☐ WNL ☐ Impaired

Hearing: ☐ WNL ☐ Impaired

Edema:

Oriented: ☐ Person ☐ Place ☐ Time

Muscle Tone: ☐ Good ☐ Fair ☐ Poor

Coordination: ☐ Good ☐ Fair ☐ Poor

Sensation: ☐ Good ☐ Fair ☐ Poor

Endurance: ☐ Good ☐ Fair ☐ Poor

Posture: ☐ Good ☐ Fair ☐ Poor

Evaluation of Cognitive and/or Emotional Functioning

Pain Assessment

☐ No Pain Reported

	Location	*Intensity:*						
Primary Site:		☐ 0 None	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5 Medium	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 High
Secondary Site:		☐ 0 None	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5 Medium	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 High

Increased by:

Relieved by:

Interferes with:

OT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /

ROM / Strength

		ROM		Strength				ROM		Strength	
Part	***Action***	***Right***	***Left***	***Right***	***Left***	***Part***	***Action***	***Right***	***Left***		
Shoulder	Flexion					Forearm	Pronation				
	Extension						Supination				
	Abduction					Wrist	Flexion				
	Adduction						Extension				
	Int Rot						Radial Deviation				
	Ext Rot						Radial Deviation				
Elbow	Flexion					Finger	Grip				
	Extension						Extension				
	Supination						Extension				

Comments:

Functional Assessment

Independence scale key: *hover over term for definition*

Dep	Max Assist	Mod Assist	Min Assist	CGA	SBA	Supervision	Mod Indep Indep

Balance

☐ Able to assume / maintain midline orientation

Sitting Static: ☐ Good ☐ Fair ☐ Poor ☐ Other (See Comments) Dynamic: ☐ Good ☐ Fair ☐ Poor ☐ Other (See Comments)

Standing Static: ☐ Good ☐ Fair ☐ Poor ☐ Other (See Comments) Dynamic: ☐ Good ☐ Fair ☐ Poor ☐ Other (See Comments)

Deficits Due To / Comments:

OT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /

Bed Mobility

	Assist Level		Assistive Device
Rolling		☐ L ☐ R	
Supine - Sit			
Sit - Supine			

Deficits Due To / Comments:

Transfer

	Assist Level	Assistive Device
Sit - Stand		
Stand - Sit		
Bed - Chair		
Chair - Bed		
Toilet or BSC		
Shower		
Tub		
Car / Van		

Deficits Due To / Comments:

Self Care Skills

	Assist Level	Assistive Device
Toileting / Hygiene		
Oral Hygiene		
Grooming		
Shaving		
Bathing		
Dressing: Upper Body		
Lower Body		
Manipulation of Fasteners		
Socks & Shoes		
Feeding		
Swallowing		

Deficits Due To / Comments:

Instrumental ADLs

	Assist Level	Assistive Device
Light Housekeep		
Light Meal Prep		
Clothing Care		
Use of Telephone		
Manage Money		
Manage Medication		
Home Safety Awareness		

Deficits Due To / Comments:

Functional Assessment

Dep	Max Assist	Mod Assist	Min Assist	CGA	SBA	Supervision	Mod Indep	Indep

Motor Coordination

Prior to Injury

Dominance: ☐ Right handed ☐ Left handed

			Deficits Due To
Fine Motor	☐ WNL	☐ Impaired	
Gross Motor	☐ WNL	☐ Impaired	

Comments:

Cognitive Status / Perception

			Deficits Due To
Memory: Short Term	☐ WNL	☐ Impaired	
Memory: Long Term	☐ WNL	☐ Impaired	
Safety Awareness	☐ WNL	☐ Impaired	
Judgment	☐ WNL	☐ Impaired	
Visual Comprehension	☐ WNL	☐ Impaired	
Auditory Comprehension	☐ WNL	☐ Impaired	
Stereognosis	☐ WNL	☐ Impaired	
Spatial Awareness	☐ WNL	☐ Impaired	
Ability to Express Needs	☐ WNL	☐ Impaired	
Attention Span	☐ WNL	☐ Impaired	

Comments:

Fall Risk and Functional Testing

				Result
Test 1	☐ ADL Index	☐ Lawton IADL	☐ Physical Performance Test (PPT)	
	☐ Katz Index of ADL	☐ Motor Assessment Scale	☐ Mini Mental Status Exam (MMSE)	
	☐ Barthel ADL Index	☐ Nine Hole Peg Test	☐ Instrumental ADL Scale (IADLS)	
Test 2	☐ ADL Index	☐ Lawton IADL	☐ Physical Performance Test (PPT)	
	☐ Katz Index of ADL	☐ Motor Assessment Scale	☐ Mini Mental Status Exam (MMSE)	
	☐ Barthel ADL Index	☐ Nine Hole Peg Test	☐ Instrumental ADL Scale (IADLS)	

OT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /

Test 3

- ☐ ADL Index
- ☐ Katz Index of ADL
- ☐ Barthel ADL Index
- ☐ Lawton IADL
- ☐ Motor Assessment Scale
- ☐ Nine Hole Peg Test
- ☐ Physical Performance Test (PPT)
- ☐ Mini Mental Status Exam (MMSE)
- ☐ Instrumental ADL Scale (IADLS)

Evaluation and Testing Description

DME

Available

- ☐ Wheelchair
- ☐ Walker
- ☐ Hospital Bed
- ☐ Beside commode
- ☐ Raised Toilet Seat
- ☐ Tub / Shower Bench
- ☐ Splints
- ☐ Cane
- ☐ Reacher
- ☐ Sock Donner
- ☐ Dressing Stick
- ☐ Shower Chair
- ☐ Long-Handled Sponge

Other:

Needs

Evaluation Assessment

Evaluation Assessment Summary

Functional Limitations

- ☐ Decreased ROM / Strength
- ☐ Impaired Balance / Gait
- ☐ Increased Pain
- ☐ Decreased Endurance
- ☐ Decreased Transfer Ability
- ☐ Decreased Bed Mobility
- ☐ Decreased Self-Care
- ☐ Poor Safety Awareness

Comments:

Short Term Treatment Goals

	Goal	Target Date
1.		/ /
2.		/ /
3.		/ /
4.		/ /
5.		/ /
6.		/ /
7.		/ /
8.		/ /
9.		/ /
10.		/ /

Long Term Treatment Goals

	Goal	Target Date
1.		/ /
2.		/ /
3.		/ /
4.		/ /
5.		/ /
6.		/ /
7.		/ /
8.		/ /
9.		/ /
10.		/ /

OT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /

Treatment Plan

☐ Thera Ex
☐ Establish or Upgrade HEP
☐ Transfer Training
☐ Balance Training
☐ Bed Mobility Training
☐ Stairs / Steps Training
☐ Range of Motion
☐ Muscle Re-education
☐ Orthotics / Splinting
☐ Manual Therapy
☐ Strength / Endurance Training
☐ Fine Motor Coordination Training
☐ Perceptual Motor Training
☐ Neuro-developmental Training
☐ Sensory Treatment
☐ O2 Sat Monitoring PRN
☐ Home Safety Training
☐ Independent Living / ADL Training
☐ Low Vision Training
☐ Assistive Device Training (specify):
☐ Adaptive Equipment Fabrication and/or Training (specify):
☐ Modalities for Pain Control (specify):
☐ Retraining of Cognitive, Feeding & Perception (specify):

Other (specify):

Comments:

Care Coordination

Conference With
☐ PT ☐ PTA ☐ OT ☐ COTA ☐ ST ☐ SN ☐ Aide ☐ Supervisor
Other:

Name(s):

Regarding:

☐ Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction

Other Discipline Recommendations: ☐ PT ☐ ST ☐ MSW ☐ Aide
Other:

Reason:

Statement of Rehab Potential

OT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /

Treatment / Skilled Intervention This Visit

Frequency and Duration

	Start Date	End Date	Effective Date	Frequency
Current Episode:	/ /	/ /	/ /	
Next Episode:	/ /		/ /	

Discharge Plan

☐ To self care when goals met ☐ To self care when max potential achieved ☐ To outpatient therapy with MD approval

☐ Other:

Signature and Title: **Date:** / /

OT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /