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		
SELF CARE SKILLS					
FEEDING			TOILETING		
SWALLOWING			BATHING		
FOOD TO MOUTH			UE DRESSING		
ORAL HYGIENE			LE DRESSING		
GROOMING			MANIPULATION OF FASTENERS		
INSTRUMENTAL ADL'S					
LIGHT HOUSEKEEPING			USE OF TELEPHONE		
LIGHT MEAL PREPARATION			MONEY MANAGEMENT		
CLOTHING CARE			MEDICATION MANAGEMENT		

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 (BED MOBILITY, TRANSFERS, BALANCE, W/C SKILLS)

GRADE	DESCRIPTION
5	Independent - physically able and independent.
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) - 100% patient/client effort.
2	Minimum assist (Min A) - 75% patient/client effort.
1	Maximum assist (Max A) - 25% - 50% patient/client effort.
0	Totally dependent - total care/support.

SUMMARY

❑ OT Evaluation only. No further indications for service.

❑ Orders for OT evaluation only. Needs additional services, see OT Care Plan.

❑ Need to obtain verbal orders.

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

Instruction provided: ❑ Safety ❑ Exercise ❑ Other (describe) _____

Need equipment (describe) _____

DISCHARGE DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify) _____

CARE COORDINATION: ❑ Physician ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ Other (specify) _____

APPROXIMATE NEXT VISIT DATE ____/____/____

PLAN FOR NEXT VISIT _____

PATIENT SIGNATURE (if applicable): _____

THERAPIST SIGNATURE/TITLE _____ **DATE** ____/____/____ **Time In** _____ **Time Out** _____