Community Therapy SERVICES

OCCUPATIONAL THERAPY ASSESSMENT FORM

INITIAL /REVIEW

OCCUPATIONAL THERAPIST: _____ **DATE:** _____

DIAGNOSIS/HISTORY: CHART REVIEWED: ☐ **Relevant info as indicated:** _____

MENTAL STATUS/COMMUNICATION (orientation, behaviour, speech, visual and/or auditory limitations):

PHYSICAL STATUS: Range of motion/strength/tone/co-ordination:

R upper limb _____

L upper limb _____

R lower limb _____

L lower limb _____

Trunk/pelvis (spinal abnormalities, etc.) _____

Balance (static, dynamic) _____

Pain (Pain Scale, PainAD) _____

Skin Integrity _____

Therapeutic Sleep Surfaces _____

Orthotics/Prosthetics _____

WHEELCHAIR SEATING: **N/A** ☐

Current seating: _____

W/C assessment findings and recommendations _____

Frame: _____

Components/accessories: _____

Measurements	Inches
Hip Width	
Thigh Length	
Leg Length	
Back Length	
Chest Width	
W/C Specs	**Inches**
Seat Width	
Seat Depth	
Back Height	
Seat to Floor	

Funding: _____

FUNCTIONAL STATUS- ADL ASSISTANCE NAME/PHIN:

RESIDENT SELF-PERFORMANCE

0 Independent-no help or staff oversight at any time

1 Supervision-oversight, encouragement or cueing

2 Limited Assistance-resident highly involved in activity, staff provide guided maneuvering of limbs and/or equipment or other non-weight-bearing assistance

3 Extensive assistance-resident involved in activity, staff provide weighbearing support

4 Total dependence-full staff performance every time

8 Does not occur- activity not performed

STAFF SUPPORT REQUIRED

0 No set-up or physical help

1 Set-up help only

2 One person physical assist

3 Two + person physical assist

8 Does not occur

	RES PERFORM	STAFF SUPPORT	AX NOT NEEDED
Bed Mobility-			
Transfers-			
Walk in Room-			
Walk in Corridor-			
Locomotion on unit-			
Locomotion off unit-			
Dressing-			
Eating-			
Toilet use-			
Personal hygiene-			
Additional Information:			

TARGET OUTCOMES:

RECOMMENDATIONS:

SIGNATURE: