CTS OCCUPATIONAL THERAPY ASSESSMENT FORM

INITIAL / REVIEW **CONSENT provided/implied by:** Resident ☐ Other ☐ _____

OCCUPATIONAL THERAPIST:_____ **DATE:** _____

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

COGNITIVE STATUS/COMMUNICATION/BEHAVIORS (orientation, behavior, 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/Trunk Control (static, dynamic) _____
Pain (Pain Scale, PainAD) _____
Skin Integrity _____

Therapeutic Sleep Surfaces _____
Orthotics/Prosthetics _____
Swelling _____
Other Information _____

WHEELCHAIR SEATING: N/A ☐

Current seating: _____

Frame: _____
Components/accessories: _____

Assessment Findings and Recommendations: _____

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	

FUNCTIONAL STATUS- ADL ASSISTANCE **NAME and PHIN:**

RESIDENT 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. Staff provide weight-bearing 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

	Resident Performs	Staff Support	Ax Not Needed
Bed Mobility (method, equipment)			
Transfers (method, equipment)			
Walking (equipment, assistance, tolerance, fall risk, footwear)			
Wheelchair (continuation of page 1, including usage, ability to self-propel)			
Bathing (method, equipment)			
Toileting (method, equipment)			
Dressing/Grooming			

Additional Information (include FRAT, MOS as appropriate)

EQUIPMENT: (e.g. mobility equipment, hip protectors, splints, off-loading AFO's, compression stockings, sliders, transfer pole, transfer belt, Derma-savers, chair/bed alarms, etc.)

OCCUPATIONAL PERFORMANCE ISSUES:

RECOMMENDATIONS:

OT SIGNATURE: