**[Company Name]**

**Inpatient Occupational Therapy Evaluation**

|  |  |
| --- | --- |
| **Patient Name:** | **Physician Name:** |
| **Diagnosis:** | **Onset Date:** |
| **Precautions:** |
| **Past Medical History:** |
|  |
| **Patient/Family Goals:** |
|  |
| **Previous Level of Function:** |
| **Social Environment (Living Arrangements, Equipment, Etc.)** |
|  |
|  |
| **Physical Assessment** |
| **Speech:** 🞏 WNL 🞏 Impaired **Vision:** 🞏 WNL 🞏 Impaired **Hearing:** 🞏 WNL 🞏 Impaired |
| **UE ROM:** |
|  |
| **UE Strength:** |
|  |
| **Subluxation:** 🞏 Yes 🞏 No **Fine Motor Coordination:** 🞏 WNL 🞏 Impaired **Gross Motor Coordination:** 🞏 WNL 🞏 Impaired |
| **Hand Dominance:** 🞏 Right 🞏 Left  |
| **Transfers:**  🞏 Independent 🞏 SBA 🞏 Minimal Assist 🞏 Moderate Assist 🞏 Maximum Assist 🞏 Total Assist |
| **Bed Mobility:** 🞏 Independent 🞏 SBA 🞏 Minimal Assist 🞏 Moderate Assist 🞏 Maximum Assist 🞏 Total Assist |
| **Balance: Sitting Static** 🞏 Good +/- 🞏 Fair +/- 🞏 Poor +/- **Dynamic** 🞏 Good +/- 🞏 Fair +/- 🞏 Poor +/-  |
|  **Standing Static** 🞏 Good +/- 🞏 Fair +/- 🞏 Poor +/- **Dynamic** 🞏 Good +/- 🞏 Fair +/- 🞏 Poor +/-  |
| **ADL’s:** |
|  |
|  |
| **Sensation:** 🞏 Intact 🞏 Impaired 🞏 Absent  |
| **Skin:** |
| **Pain Level/Precipitating Factors/Aggravating Factors:** |
|  |
| **Barriers to Learning:** |
| **Rehab Potential:** 🞏 Good 🞏 Fair 🞏 Poor  |
| **Assessment:** |
|  |
|  |
|  |
| **Goals:** |
|  |
|  |
|  |
|  |
|  |
| **Treatment Plan:** |
|  |
|  |
| **THERAPIST’S SIGNATURE:** | **PHYSICIAN’S SIGNATURE:** |
| **DATE:** | **DATE:** |