**[Company Name]**

**Inpatient Occupational Therapy Evaluation**

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| **Patient Name:** | **Physician Name:** |
| **Diagnosis:** | **Onset Date:** |
| **Precautions:** | |
| **Past Medical History:** | |
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| **Patient/Family Goals:** | |
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| **Previous Level of Function:** | |
| **Social Environment (Living Arrangements, Equipment, Etc.)** | |
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| **Physical Assessment** | |
| **Speech:** 🞏 WNL 🞏 Impaired **Vision:** 🞏 WNL 🞏 Impaired **Hearing:** 🞏 WNL 🞏 Impaired | |
| **UE ROM:** | |
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| **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:** | |
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|  | |
| **Sensation:** 🞏 Intact 🞏 Impaired 🞏 Absent | |
| **Skin:** | |
| **Pain Level/Precipitating Factors/Aggravating Factors:** | |
|  | |
| **Barriers to Learning:** | |
| **Rehab Potential:** 🞏 Good 🞏 Fair 🞏 Poor | |
| **Assessment:** | |
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| **Goals:** | |
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| **Treatment Plan:** | |
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| **THERAPIST’S SIGNATURE:** | **PHYSICIAN’S SIGNATURE:** |
| **DATE:** | **DATE:** |