[Company Name]
Home Health Occupational Therapy Evaluation & Physician's Certification

CHECK ONE: ☐ ASSESSMENT ONLY ☐ ADMISSION ☐ RECERTIFICATION ☐ DISCHARGE

Patient Name:			**Phone Number:**	
Address:			**PT#:**	
Primary Diagnosis:				**Onset:**
Secondary Diagnosis:				**Onset:**
Rehab Potential: ☐ Excellent ☐ Good ☐ Fair ☐ Poor			**Mental Status:**	
ADL-FUNCTIONAL ABILITY: Codes Independent (0%), Stand-By Assist (1-10%), Min Assist (11-29%), Mod Assist (30-69%), Max Assist (70-100%)			**OBJECTIVE FINDINGS:** Codes Max, Mod, Min, Good, Fair, Poor	
DRESSING:			ROM:	
UPPER EXTREMITY:				
LOWER EXTREMITY:			MUSCLE STRENGTH:	
ADAPTIVE DEVICES:				
FEEDING:			SENSATION:	
UTENSIL:			ARCHITECTURAL ASSESSMENT/HOME EVALUATION:	
GLASS:				
CUTTING:				
GROOMING & HYGIENE:			PAIN LEVEL: Relieved with Meds? ☐ Y ☐ N	
HAIR:			LOCATION: Agency Notified? ☐ Y ☐ N	
TEETH:			EQUIPMENT NEEDS:	
BATH/SHOWER:			TREATMENT CODES: (CHECK ALL THAT APPLY)	
NAILS:			☐ D1 Evaluation ☐ D6 Neuro Development Tx.	
COSMETICS:			☐ D2 ADL Training ☐ D7 Sensory Treatment	
SHAVING:			☐ D3 Muscle Re-Education ☐ D8 Orthotics/Splinting	
URINAL/TOILET:			☐ D4 Perceptual Motor Training ☐ D9 Adaptive Equipment	
COORDINATION:			☐ D5 Fine Motor Training ☐ D10 Other	
GROSS MOTOR:			☐ HISTORY & PHYSICAL UPDATED ☐ DISCHARGE	
FINE MOTOR:				
BILATERAL:				
HAND DOMINANCE:				
PERCEPTUAL MOTOR:				
HOMEMAKING:			☐ TREATMENT PLAN/PLAN OF CARE:	
KITCHEN:				
LAUNDRY:				
HOUSEWORK:				
OTHER:				
☐ GOALS ☐ DISCHARG STATUS ☐ HOME PROGRAM GIVEN			COMMENTS:	
GOALS:				
			TIME IN:	
FREQUENCY VISITS:			TIME OUT:	
In my judgment, the above named patient is homebound?			ESTIMATE TIME ON SERVICES:	
☐ Yes ☐ No			PHYSICIAN'S NAME (Print):	
OCCUPATIONAL THERAPIST'S SIGNATURE:			PHYSICIAN'S SIGNATURE:	
DATE:			DATE:	