[Company Name]

Occupational Therapy

Occupational Therapy Services
_____Evaluation
_____Re-Evaluation
_____Discharge Summary

Patient Name	HIC#: Medicaid#:
Address	D.O.B:
Primary Diagnosis:	Onset:
Secondary Diagnosis:	Phone No.:

Codes
Strength – N = Normal G = Good P = Poor T = Trace 0 = Zero
Range of Motion - N = Normal F = Functional ML = Moderate Limit S = Severe

Codes
I = Independent C = Cueing Required
A = Assistance Needed U = Unable to Perform
E = Equipment Needed

Nine-Hole Peg Test Score - Right Left

		Right			Left		
		PROM	AROM	MMT	PROM	AROM	MMT
Shoulder	Flexion 0-180----------						
	Extension 0-50--------						
	Abduction 0-160-------						
	Internal Rotation 0-70						
	External Rotation 0-90						
Elbow	Flexion 0-145----------						
	Extension----------						
Forearm	Pronation 0-85---------						
	Supination 0-85--------						
Wrist	Flexion 0-70----------						
	Extension 0-70---------						
Thumb	Flexion----------						
	Extension----------						
Finger	Flexion----------						
	Extension----------						
HAND	DOMINANCE ☐ RIGHT ☐ LEFT	GRIP STRENGTH RIGHT lbs.			LEFT lbs.		

ACTIVITY	I	C	A	U	E
Dressing----------					
Bathing Tub----------					
Bathing Shower----------					
Bathing Bed----------					
Grooming/Hygiene----------					
Toileting----------					
Homemaking----------					
Eating----------					
Bed Mobility----------					
Ambulation----------					
Bed-Wheelchair-					
Chair-Wheelchair					
Transfers Toilet----------					
Tub/Shower------					
Car----------					
Brushing Teeth----------					

SENSATION

CODE – 3 = Intact 2 = Impaired 1 = Absent

	LEFT	RIGHT
LIGHT TOUCH		
SHARP/DULL		
STEREOGNOSIS		
KINESTHESIA		
PROPRIOCEPTION		

COGNITIVE STATUS

CODE - 4 = Intact 3 = Minimally Impaired 2 = Moderately Impaired 1 = Maximally Impaired

ALERTNESS----------
COOPERATION----------
ATTENTION SPAN----------
ORIENTATION----------
MEMORY----------
FOLLOW DIRECTIONS------

PERCEPTUAL DEFICIT

ENDURANCE

COORDINATION

In my judgement, the above named patient is “homebound”. ☐ Yes ☐ No

TREATMENT TIME (Amount):	FREQUENCY OF VISITS:	ESTIMATED TIME ON SERVICES (Duration):

Therapist’s Name (Print)	Physician’s Name (Print)
Therapist’s Signature Date	Physician’s Signature Date

Revised: _____