EVALUATION/SCREEN

Patient Name:_____

Date:_____ **Reason for Screen: Adm / Ann / Quart / Refer /Other**_____

	WNL /WFL / Limited				WNL /WFL / Limited		
RIGHT	**PROM**	**Strgth**	**Comments/Contractures**	**LEFT**	**PROM**	**Strgth**	**Comments/Contractures**
UE				**UE**			
LE				**LE**			

W/C Mobility: **I, SUP, CG, CG/Min, MinA, Min/ModA, ModA, Mod/MaxA, MaxA, ModAx2, MaxAx2, TD NA/NT**
Bed Mobility incl sup<>sit: **I, SUP, CG, CG/Min, MinA, Min/ModA, ModA, Mod/MaxA, MaxA, ModAx2, MaxAx2, TD NA/NT**
Transfers: **I, SUP, CG, CG/Min, MinA, Min/ModA, ModA, Mod/MaxA, MaxA, ModAx2, MaxAx2, TD NA/NT**
Feeding: **I, SUP, CG, CG/Min, MinA, Min/ModA, ModA, Mod/MaxA, MaxA, ModAx2, MaxAx2, TD NA/NT**
Hyg/Groom: **I, SUP, CG, CG/Min, MinA, Min/ModA, ModA, Mod/MaxA, MaxA, ModAx2, MaxAx2, TD NA/NT**
UB/LB Dressing: **I, SUP, CG, CG/Min, MinA, Min/ModA, ModA, Mod/MaxA, MaxA, ModAx2, MaxAx2, TD NA/NT**
Toileting: **I, SUP, CG, CG/Min, MinA, Min/ModA, ModA, Mod/MaxA, MaxA, ModAx2, MaxAx2, TD NA/NT**
Ambulation: **I, SUP, CG, CG/Min, MinA, Min/ModA, ModA, Mod/MaxA, MaxA, ModAx2, MaxAx2, TD NA/NT**
Primary Mean of Locomotion:_____**Asst Dev or Amb dev needed?** NO/ Yes_____
Standing Balance: Norm Good Good- Fair+ Fair Fair- Poor+ Poor Unbl DNT
Sitting Balance: Norm Good Good- Fair+ Fair Fair- Poor+ Poor Unbl DNT
HX of Falls: NO/ Yes_____ **Risk for Falls:** NO/ Yes_____
Is pt on RNP? NO/ Yes **If Yes, does it need modification?** NO/ Yes **If No, does pt need one?** NO/Yes_____
Positioning problems/Restrains: _____ **Visual issues:**_____
Wound/Edema: NO/ Yes_____ **Pain:** NO/ Yes **Intensity:** _____**Location:** _____ **Does it limit fxn?** NO /YES_____
Swallowing issues:_____ **Communication Issues:** _____**Cognitive Issues:**_____
Has there been a decline since the last screen? NO/ Yes_____

Does Patient require: PT eval / OT eval / ST eval / RNP program / RNP modification

Recommends: _____**Therapist Sign/Lisc#:**_____

_____
_____
_____

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