

Transfers									
Bed to Chair									
Gait Assistance									
Wheelchair (Self Propel)									

Occupational Therapy

Date of Review: ___/___/___ Hours per: Day ___ Week ___

LE Strength: _____ UB Strength: _____

Sitting Balance: _____ Endurance: _____

	I	Mod I	S	CG	SU	Min A	Mod A	Max A	D
Feeding									
Grooming									
Bathing UE									
Bathing LE									
Dressing UE									
Dressing LE									
Toilet Transfer									
Toileting									

Speech Therapy:

Date of Review: ___/___/___ Hours per: Day ___ Week ___

Swallowing: _____ Communication: _____

Cognition: _____ Diet: _____

Comments: _____

Medications:

Scheduled IV Medications: _____

IV Medication End Date: _____

Wound Care

Date of Evaluation: ___/___/___ Next Dressing Change: ___/___/___

Wound Location(s): _____

Wound Type: ___ Surgical ___ Pressure ___ Venous ___ Diabetic ___ Other: _____

Measurement (L x W x D): _____ x _____ x _____ cm

Deep Tissue Exposed (bone, tendon, fascia) (Yes/No) _____

Frequency: ___ Daily ___ BID ___ 3x Weekly ___ Other: _____

Complex Wound Needs (e.g., infection management, debridement, NPWT):

Estimated Discharge Date and Plan:

Barriers to Discharge:
