

UNKNOWN TEXT Last	First	MR#	SSN - -	Date / /
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Ox	PRIOR LEVEL OF FUNCTION: <input type="checkbox"/> I <input type="checkbox"/> S <input type="checkbox"/> SBA <input type="checkbox"/> CBA <input type="checkbox"/> MIA (A) <input type="checkbox"/> MOD (A) <input type="checkbox"/> MAY (A) <input type="checkbox"/> UN <input type="checkbox"/> W/C BOUNT
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UNKNOWN TEXT Merchant XX	<input type="checkbox"/> BED BOUND - WITH: <input type="checkbox"/> ADUS <input type="checkbox"/> GACT <input type="checkbox"/> TRANS / THS
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Home bound Status: Needs assistance for all activities Residual weakness Requires assistance to ambulate Confusion, unable to go out of home Alone Unable to safely leave home unassisted Severe SOB, SOB upon exertion Dependent upon adaptive device(s) Bed bound W/C bound

OBJECTIVE ASSESSMENT (Skilled Observation): INITIAL RECENT RESUME

PAIN ASSESSMENT: Pt has no pain Less often than daily Daily but not constantly All of the time BP: / P: R:

Scale: (Adult 0-10) severity /10 At rest with activity Location:

PROBLEMS IDENTIFIED	GOALS	EST. COMPLETION DATE
1.	1.	/ /
2.	2.	
3.	3.	
4.	4.	
5.	5.	
6.	6.	

SAFETY MEASURES At risk for falls Cluttered living area / rugs and cords Living area appears safe at this time
 Steps: Other

MENTAL STATUS Oriented Forgetful Disoriented Agitated Comatose Depressed Can Follow Commands
 Other

PROGNOSIS Poor Guarded Fair Good Excellent

REHAB POTENTIAL Good for stated goals Other

DISCHARGE PLANS Client to remain independent in home Client to remain in home with assistance as needed
 Other

ORDERS: FREQUENCY / DURATION W ; W ; W ; **EFFECTIVE:** / /

Evaluation: Functional Status

Level of Assistance: I=Independent, S=Supervised, Min=Minimal Assist, Mod=Moderate Assist, Max=Maximal Assist, U=Unable, NT=Not Tested

Bed Mobility	Transfers	ADL
Roll/Scoot: <input type="checkbox"/>	Bed/Chair: <input type="checkbox"/>	Dressing: <input type="checkbox"/>
Supine to Sit: <input type="checkbox"/>	W/C: <input type="checkbox"/>	Personal Hygiene: <input type="checkbox"/>
Sit to Suplne: <input type="checkbox"/>	Toilet: <input type="checkbox"/>	Bathing: <input type="checkbox"/>
	Shower: <input type="checkbox"/>	Feeding: <input type="checkbox"/>
		Meci Prep: <input type="checkbox"/>
		Home Making: <input type="checkbox"/>

Gait Description
 Levels
 Staks
 Analysis:

Functional Limitations
 Amputation
 Bowel/Bladder
 Contractures
 Hearing

Actives Permitted
 Complete bed rest
 Bed rest w/DRP
 Transfer bed/chair
 Exer. prescribed

PLAN OF CARE:

Therapeutic exercise:
 Balance Training
 Bed Mobility Training
 Transfer Training:
 Gait training: even surfaces uneven surfaces
 Stairs/Steps Training: Electrotherapy (site)
 Therapeutic mobilization Prosthetic training
 Massage to (site): Muscle re-education
 Ultrasound Microwave diathermy-

Teaching: Patient CRE Family

ESTB Home Exercise Program BUE BLE TRUNK / Back
 Energy conservation technique Functional Training
 Safety awareness protocol Disease Process
 Body mechanics Hip Replacement Protocol
 Joint Protection Knee Replacement Protocol
 Conservative pain management Post surgical protocol
 Fall Protection Emergency Protocol
 Equipment Training: Discharge Plan