GTA REHAB Network

## FUNCTIONAL INFORMATION - Burns

To be completed by Allied Health Team

**Patient's Name:**

**Premorbid function:** ☐ Independent in ADL ☐ Dependent in ADL

Comments: ______________________________

**Self Care:**

| | | | | |
|---|---|---|---|---|
| Dressing: | ☐ Independent | ☐ Total assistance | ☐ Partial assistance | ☐ Supervision only |
| Bathing: | ☐ Independent | ☐ Total assistance | ☐ Partial assistance | ☐ Supervision only |

Comments: ______________________________

**Swallowing:** ☐ Intact, regular diet ☐ Dental soft diet ☐ Minced diet ☐ Pureed diet ☐ Thickened fluids

Comments: ______________________________

**Feeding:** ☐ Independent ☐ Supervision required ☐ Partial assistance ☐ Total assistance ☐ Tube feed

Comments: ______________________________

**Transfers:** ☐ Mechanical lift ☐ 2 person ☐ 1 person ☐ Supervision only ☐ Independent ☐ On bed rest

Comments: ______________________________

**Ambulation:** ☐ Non-ambulatory ☐ 2 person ☐ 1 person ☐ Supervision only ☐ Independent ☐ Distance *(specify)* ______________

Comments: ______________________________

**Mobility aide:** ☐ Standard Walker ☐ Rollator ☐ Wheelchair ☐ Cane ☐ Crutches ☐ 2 Wheeled Walker ☐ Other (specify)

Comments: ______________________________

**Limbs:** ☐ Normal ☐ Left sided impairment ☐ Right sided impairment ☐ Bilateral impairment ☐ U/E impairment ☐ L/E impairment ☐ Impaired coordination ☐ Reduced strength ☐ Other ______________

Comments: ______________________________

## FUNCTIONAL INFORMATION – Burns (cont'd)

To be completed by Allied Health Team

**Patient's Name:**

**Participation Level:** Specify:
On average, patient is able to participate in _________ therapy sessions / day, _________times / week for ____________minutes / session.

Sitting Tolerance ☐ Full ☐ Limit ☐ N/A ☐ Restrictions/ Duration ____________________

**Communication:**
Language expression: ☐ Intact ☐ Only able to express basic needs ☐ Uses gesturing ☐ Completely impaired
Language comprehension: ☐ Intact ☐ Follows basic instructions ☐ Impaired ____________________________________________
Comments: ____________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

| **Cognitive Status:** | Not Tested | Intact | Impaired |
|---|---|---|---|
| Attention | ☐ | ☐ | ☐ *(specify):* |
| Able to follow instructions | ☐ | ☐ | ☐ *(specify):* |
| Memory (short term) | ☐ | ☐ | ☐ *(specify):* |
| Memory (long term) | ☐ | ☐ | ☐ *(specify):* |
| Carry-Over/New Learning | ☐ | ☐ | ☐ *(specify):* |
| Judgment | ☐ | ☐ | ☐ *(specify):* |
| Insight | ☐ | ☐ | ☐ *(specify):* |
| Other | ☐ | ☐ | ☐ *(specify):* |
| MMSE Score: ______ | ☐ | If did not/unable to complete, please explain: | |

**Briefly describe the rehabilitation goals** *(Be specific — e.g. increased mobility, speech, community living skills, etc.)*

PT Progress & Plan

OT Progress & Plan

SLP Progress & Plan

**Form completed by:** (Include name/telephone/date)