

**FUNCTIONAL INFORMATION - CCC**

To be completed by Allied Health Team

<b>Patient's Name:</b> _____	
<b>Premorbid function:</b> <input type="checkbox"/> Independent in ADL <input type="checkbox"/> Dependent in ADL Comments: _____ _____ _____	
<b>Alcohol Abuse:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Episodic <input type="checkbox"/> Active	<b>Drug Abuse:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Episodic <input type="checkbox"/> Active
<b>Self Care:</b> Dressing: <input type="checkbox"/> Independent <input type="checkbox"/> Total assistance <input type="checkbox"/> Partial assistance <input type="checkbox"/> Supervision only Bathing: <input type="checkbox"/> Independent <input type="checkbox"/> Total assistance <input type="checkbox"/> Partial assistance <input type="checkbox"/> Supervision only Comments: _____ _____ _____	
<b>Swallowing:</b> <input type="checkbox"/> Intact, regular diet <input type="checkbox"/> Dental soft diet <input type="checkbox"/> Minced diet <input type="checkbox"/> Pureed diet <input type="checkbox"/> Thickened fluids Comments: _____ _____ _____	
<b>Feeding:</b> <input type="checkbox"/> Independent <input type="checkbox"/> Supervision required <input type="checkbox"/> Partial assistance <input type="checkbox"/> Total assistance <input type="checkbox"/> Tube feed <input type="checkbox"/> Barium Swallow study done? <input type="checkbox"/> No <input type="checkbox"/> Yes        Repeat Barium Swallow study required? <input type="checkbox"/> No <input type="checkbox"/> Yes    Date: _____ Comments: _____ _____ _____	
<b>Transfers:</b> <input type="checkbox"/> Mechanical lift <input type="checkbox"/> 2 person <input type="checkbox"/> 1 person <input type="checkbox"/> Supervision only <input type="checkbox"/> Independent <input type="checkbox"/> On bed rest Comments: _____ _____ _____	
<b>Ambulation:</b> <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> 2 person <input type="checkbox"/> 1 person <input type="checkbox"/> Supervision only <input type="checkbox"/> Independent <input type="checkbox"/> Distance ( <i>specify</i> ) _____ Comments: _____ _____ _____	
<b>Mobility aide:</b> <input type="checkbox"/> Standard Walker <input type="checkbox"/> Rollator <input type="checkbox"/> Wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> 2 Wheeled Walker <input type="checkbox"/> Other ( <i>specify</i> ) _____ Comments: _____ _____ _____	
<b>Limbs:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Left sided impairment <input type="checkbox"/> Right sided impairment <input type="checkbox"/> Bilateral impairment <input type="checkbox"/> U/E impairment <input type="checkbox"/> L/E impairment <input type="checkbox"/> Impaired coordination <input type="checkbox"/> Reduced strength <input type="checkbox"/> Other _____ Comments: _____ _____ _____	

## FUNCTIONAL INFORMATION – CCC (cont'd)

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**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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Cognitive Status:</b>	Not Tested	Intact	Impaired	
Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):	
Able to follow instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):	
Memory (short term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):	
Memory (long term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):	
Carry-Over/New Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):	
Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):	
Insight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):	
MMSE Score: _____	<input type="checkbox"/>	If did not/unable to complete, please explain:		

**Does this patient have any long-term rehab goals?**    No     Yes    If yes, please specify below: (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)