

**FUNCTIONAL INFORMATION - General/Medical**

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>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
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 (specify) _____			
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 - General/Medical  
(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: \_\_\_\_\_

\_\_\_\_\_

<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:	

**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)