

FUNCTIONAL INFORMATION – MSK (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	<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)