

FUNCTIONAL INFORMATION – Respiratory/Chronic Ventilation

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
 Cough Gag

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 – Respiratory/Chronic Ventilation (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)