

FUNCTIONAL INFORMATION - Trauma

To be completed by Allied Health Team

Patient's Name:	Cause of injury:
Premorbid function: <input type="checkbox"/> Independent in ADL <input type="checkbox"/> Dependent in ADL Comments: _____ _____ _____	
Self Care: 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: _____ _____ _____	
Swallowing: <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 <input type="checkbox"/> Jaws wired Comments: _____ _____ _____	
Feeding: <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: _____ _____ _____	
Transfers: <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: _____ _____ _____	
Ambulation: <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: _____ _____ _____	
Mobility aide: <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: _____ _____ _____	
Limbs: <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 – Trauma (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: _____

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)