

ACTIVITY THERAPY ASSESSMENT
CSH-188

To be imprinted with client stamp plate by ward personnel.

This form is used by the Activity Therapy Department to assess the client's needs for and ability to participate in Activity Therapy.

This form is completed by the Activity Therapist.

The patient/resident is referred for Activity Therapy by the Treatment Team. The Activity Therapist then has 15 days to assess the client's needs and abilities. At that time the Activity Therapy Service Plan must be done and is recorded on the client's Individual Treatment Plan, stating the name(s) of activity(ies), the time, place and duration of the activity.

In the skilled nursing areas, the Activity Therapist will assess all clients prior to the formulation of the Individual Treatment Plan.

The attending physician must initial the Activity Service Plan addition.

The activity Therapy Assessment is filed in the client's medical record.