

Central State Hospital620 Broad St.
Milledgeville, GA 31062**OCCUPATIONAL THERAPY EVALUATION****NAME:** _____**ADMISSION DATE:** _____**ID#:** _____**SOURCE(S) OF INFORMATION:**

Interview with the following: (Check only those which apply)

 Individual Staff member(s): _____ Family member(s) or friends: _____ Review of records (specify): _____**REASON FOR EVALUATION:** _____**PERTINENT DIAGNOSIS/MEDICATIONS:** _____**PERTINENT HISTORY:** _____**HIGH RISK CONDITIONS:** _____**24 Hour Support Plan:** Not indicated Indicated: _____**ASSESSMENT(S) ADMINISTERED:** _____**PSYCHOSOCIAL FUNCTION:****Affect:** Appropriate Labile Flat Depressed Excited Anxious Angry**Cooperation:** Cooperative Refused to participate in evaluation Limited: _____**Eye contact:** Appropriate Absent Limited: _____**Communication:** Functional Inappropriate language or tone Pressured speech Nonverbal Appears to have receptive and/or expressive language difficulty Varies across environmental contexts or settings: _____**Communication methods:** Eye gaze Vocalizations Facial expressions Gestures Sign Language Vocalizations Picture system Yes/no responses AAC Device: _____ Words: _____ Sentences or phrases: _____ Body Language: _____**Self regulation:** Able to maintain functional level of arousal Impulsive Unable to maintain functional level of arousal Uses self regulation strategies: _____**COGNITIVE FUNCTION:****Orientation and Environmental Awareness:** _____**Attention:** _____**Problem solving:** _____**Safety awareness:** _____**SENSORY AND PERCEPTUAL FUNCTION:****Visual acuity:** Functional**Visual perception:** Functional Visual field cut Spatial bias Limited visual perception and/or understanding of spatial concepts: _____**Orientation and mobility:** Functional Functional with device and/or techniques Limited by diminished environmental awareness: _____**Auditory acuity:** Functional**Auditory processing:** Functional Limited localization of sounds Hypersensitive startle response

Hypersensitivity to sound(s): _____

Olfactory and gustatory function: Functional Hypo- or hypersensitivities noted or reported: _____**Tactile function:** Functional Hypo- or hyper-responsiveness noted or reported: _____**Proprioceptive function:** Functional Hypo- or hyper-responsiveness noted or reported: _____**Vestibular function:** Functional Hypo- or hyper-responsiveness noted or reported: _____**Pain:** No pain reported Individual nonverbal and does not appear to be in pain Individual nonverbal but pain suspected: _____ Currently experiencing pain (level, location, exacerbating and alleviating factors): _____**MUSCULOSKELETAL FUNCTION:**

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OCCUPATIONAL THERAPY EVALUATION

Range of Motion: Functional Limited: See attached ROM and Strength assessment: _____

Strength: Functional Limited: See attached ROM and Strength assessment: _____

Muscle Tone: Functional

Skin Integrity: Functional Location(s) and type of current breakdown: _____

Skin breakdown potential: _____

Edema present: _____

SEATING AND POSITIONING: Indicated Not indicated

Current supports: None List type, usage, adaptations: _____

Wheelchair assessment: Indicated Not indicated

Observations: _____

Bed positioning/Alternate positioning: Not indicated Sidelying Quadraped on forearms Prone on forearms

Other: _____

Results: _____ Impact of alternate positioning on functional ability, participation and socialization: _____

GROSS MOTOR FUNCTION:

Functional Balance:

Sitting: Functional Core weakness observed Delayed or absent righting, equilibrium, and/or protective extension reactions

Standing: Functional Unable to stand Uses wide base of support Delayed or absent righting, equilibrium, and/or protective extension reactions Standing restrictions: _____

Reaching: Functional Not observed Loses balance when reaching from sitting Loses balance when reaching from standing

Posture and alignment: _____

Mobility and Movement:

Mobility: Functional Needs assistance: _____

Transfers: Functional Needs assistance: _____

Quality of movement and motor control: _____

Endurance: Functional Limited: _____

Orthotic and Prosthetic Devices:

Not indicated Indicated but not utilized In use or recommended: _____

FINE MOTOR FUNCTION:

Hand Preference: Right

Prehension patterns: Functional Limited: _____

Coordination and control of reach, grasp and release: Functional Limited: _____

Bilateral and/or bimanual hand activity: Able to use two hands together for functional tasks Limited: _____

FUNCTIONAL MEALTIME AND DINING SKILLS AND NUTRITIONAL SUPPORTS:

	Functional ability, level of assistance and supervision	Performance components, task demands, and environment, (including Triggers, Target behaviors)	Supports and/or techniques to promote safety and/or independence (Adaptive equipment; Special procedures and techniques; Individual and staff positioning)
Mealtime and Snacks			
Oral Hygiene			

Georgia Department of Behavioral Health and Developmental Disabilities Central State Hospital 620 Broad St. Milledgeville, GA 31062 OCCUPATIONAL THERAPY EVALUATION	The individual's Identification
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Medication Administration			
Other:			

Mealtime Behaviors Observed: None Eats at fast pace Drinks at fast pace Grabs or steals food
 Large bite size
 Large sip size Talks with food or liquid in mouth Walks, paces or moves excessively while eating or drinking
 Other: _____

Activities of Daily Living: Self Care

	Functional ability, level of assistance and supervision	Performance components, task demands, and environment	Supports and/or techniques to promote safety and/or independence (Adaptive equipment; Special procedures and techniques; Positioning)
Toileting			
Dressing and Grooming			
Bathing			
Other:			

Activities of Daily Living: Work, Education, Leisure and Instrumental ADL's:

	Functional ability, level of assistance and supervision	Performance components, task demands, and environment (Environmental considerations)	Supports needed to promote independence (Adaptive equipment)
Work			
Education			
Leisure:			
Household chores			
Shopping			
Meal planning			
Money Management			

HABITS, ROLES AND ROUTINES: _____

ANALYSIS OF FINDINGS: Not indicated; please refer to Integrated Therapy Services Analysis of Findings
Individual's priorities and life goals: _____

Present functional status: _____

Environments, modalities, preferences, and/or strategies that support learning and/or performance or may hinder performance: _____

Implications for Discharge Planning: _____

Recommendations for additional assessments or evaluation: None List: _____

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OCCUPATIONAL THERAPY EVALUATION

Recommended Goal(s): _____
Recommended Objective(s): _____
Recommended Intervention(s): _____

Signature and date