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

NAME: *List individual's first and last name*
ADMISSION DATE: *List date of admission*
ID#: *List ID number*
SOURCE(S) OF INFORMATION:
Interview with the following: (Check only those which apply)
☐ Individual ☐ Staff member(s) *Specify staff name and any pertinent identifying information (e.g., staff familiar with individual, works on unit, trusted or preferred by individual)*
☐ Family member(s) or friends *Specify who was interviewed and how (e.g., by phone) and when if not interviewed during evaluation*
☐ Review of records (specify): *Document which parts of the record were reviewed, including previous assessments, evaluations, reports from consultations, diagnostic tests and/or lab work, treatment plans, and progress notes.*
REASON FOR EVALUATION: *List reason for evaluation and/or presenting problem(s)*
PERTINENT DIAGNOSIS/MEDICATIONS: *List all diagnoses and/or medications that are relevant to presenting problem(s) and current functional status.*
PERTINENT HISTORY: *Document clinical and/or personal history that may be relevant in assessing current functional status and in considering prognosis and potential treatment strategies. Include past treatment interventions and response (e.g., for pain history) as clinically indicated.*
HIGH RISK CONDITIONS: *List any medical, behavioral, and psychological risk conditions identified that could potentially impact participation in daily activities.*
24 Hour Support Plan: ☐ Not indicated ☐ Indicated: *List reason for 24 hour support plan*
ASSESSMENT(S) ADMINISTERED: *List any standardized assessments, standard assessment procedures (e.g., Range of Motion assessment, clinical observation during specific activities of daily living) or specific structured activities used for clinical observation during evaluation.*
PSYCHOSOCIAL FUNCTION: *For each item, check the most appropriate box and provide additional information as clinically indicated; this should capture the individual's current (i.e. at the time of the evaluation) psychosocial status*
Affect: ☐ Appropriate ☐ Labile ☐ Flat ☐ Depressed ☐ Excited ☐ Anxious ☐ Angry
Cooperation: ☐ Cooperative ☐ Refused to participate in evaluation ☐ Limited: *List clinically significant limitations in cooperation (e.g., individual was initially cooperative but refused to participate when assessment activities became challenging) and strengths (e.g. individual was able to cooperate within cognitive and communicative capacity)*
Eye contact: ☐ Appropriate ☐ Absent ☐ Limited: *List specific abilities (e.g., able to make but not sustain eye contact)*
Communication: ☐ Functional ☐ Inappropriate language or tone ☐ Pressured speech ☐ Nonverbal ☐ Appears to have receptive and/or expressive language difficulty ☐ Varies across environmental contexts or settings: *Describe any fluctuations in communicative functioning depending on setting, environment, or social context (e.g., with familiar staff versus strangers).*
Current communication method(s): ☐ Eye gaze ☐ Vocalizations ☐ Facial expressions ☐ Gestures ☐ Sign Language
☐ Vocalizations ☐ Picture system ☐ Yes/no responses ☐ AAC Device: *List current AAC system and/or device and effectiveness of device in communicating individuals needs and thoughts.*
☐ Words: *List any words that the individual is able to meaningfully and effectively use for communication.*
☐ Sentences or phrases: *List any sentences or phrases that the individual is able to meaningfully and effectively use for communication.*
☐ Body Language: *Describe body movements that the individual uses for expressive communication and communicative intent.*
Self regulation: ☐ Able to maintain functional level of arousal ☐ Impulsive ☐ Unable to maintain functional level of arousal

☐ Uses self-regulation strategies: *List any strategies that the individual appears to use to regulate arousal state and attention (e.g., fidgeting, chewing on pencil or pen)*

COGNITIVE FUNCTION: *For each item, check the most appropriate box and provide additional information as clinically indicated*

Orientation and Environmental Awareness: *Describe the individual's awareness of the physical environment, as well as orientation to time, place, person.*

Attention: *Describe whether the individual is able to attend to questions, task directions, presented evaluation activities, and observed tasks. List any limitations in attention span and duration, as well as limitations in focused selective and joint attention. List any sensory processing or integration issues (e.g., difficulty integrating focal and ambient input) that may impact attention.*

Problem solving: *List any observed abilities (e.g., can exhibit or verbalize functional compensatory strategies for limitations in performance) and/or difficulties (e.g. becomes frustrated when unable to solve a problem).*

Safety awareness: *Discuss awareness and basic understanding of environmental (e.g., wet floor, water temperature, street signs) and personal hazards (e.g., symptoms of low blood sugar)*

SENSORY AND PERCEPTUAL FUNCTION: *For each item, check the most appropriate box and provide additional information as clinically indicated*

Visual acuity: ☐ Functional ☐ Limited ☐ Functional with corrective lenses ☐ Refuses prescribed corrective lenses ☐ Blind **Visual perception:** ☐ Functional ☐ Visual field cut ☐ Spatial bias ☐ Limited visual perception or understanding of spatial concepts: *List any specific perceptual deficits (e.g., spatial bias, visual field cuts) and discuss resultant impact on functional performance; list any difficulties understanding spatial concepts which may affect functional activities (e.g., does not understand "backwards and forwards" needs verbal cues to put shirt on correctly)*

Orientation and mobility: ☐ Functional ☐ Functional with device and/or techniques ☐ Limited by diminished environmental awareness: *Describe abilities and needs for orientation in mobility (e.g., needs one on one physical assistance and consistent verbal cueing to use trailing program or cane)*

Auditory acuity: ☐ Functional ☐ Limited ☐ Functional with corrective device ☐ Refuses prescribed corrective device ☐ Deaf

Auditory processing: ☐ Functional ☐ Limited localization of sounds ☐ Hypersensitive startle response ☐ Hypersensitivity to sound(s): *List any sounds or noises that the individual verbalizes or demonstrates an aversive reaction to.*

Olfactory and gustatory function: ☐ Functional ☐ Hypo- or hypersensitivities noted or reported: *List any tastes or smells that the individual verbalizes or demonstrates an aversive reaction to, as well as any difficulties with taste or smell registration.*

Tactile function: ☐ Functional ☐ Hypo- or hyper-responsiveness noted or reported: *Document whether the individual appears to seek or avoid touch input, list clinical signs and symptoms that may be indicative of sensory processing problems (e.g., avoids light touch, cuts tags out of clothes, squeezes arms with hands and hugs self tightly), and discuss potential difficulties in thresholds, registration and responsiveness (e.g., appears to be hyper-responsive to light touch and hyporesponsive to deep pressure touch).*

Proprioceptive function: ☐ Functional ☐ Hypo- or hyper-responsiveness noted or reported: *Document whether the individual appears to seek or avoid proprioceptive input, list clinical signs and symptoms that may be indicative of sensory processing problems (e.g., unable to grade grasp, uses visually guided reach), and discuss potential difficulties in thresholds, registration and responsiveness (e.g., seems to have difficulty with proprioceptive registration).*

Vestibular function: ☐ Functional ☐ Hypo- or hyper-responsiveness noted or reported: *Document whether the individual appears to seek or avoid vestibular and movement input, list clinical signs and symptoms that may be indicative of sensory processing problems (e.g., seeks and engages in extreme movement sports such as skydiving, rocks body and bounces legs when sitting), and discuss potential difficulties in thresholds, registration and responsiveness (e.g., appears to have high thresholds for vestibular input).*

Pain: ☐ No pain reported ☐ Individual nonverbal and does not appear to be in pain ☐ Individual nonverbal but pain suspected: *List signs and symptoms that appear to be indicative of pain.*
☐ Currently experiencing pain (level, location, exacerbating and alleviating factors): *Describe pain using pain scale, diagram to supplement evaluation as needed. List any functional activities that are limited by pain.*
MUSCULOSKELETAL FUNCTION: *For each item, check the most appropriate box and provide additional information as clinically indicated*
Range of Motion: ☐ Functional ☐ Limited: ☐ See attached ROM and Strength assessment: *Summarize findings from ROM assessment as clinically indicated*
Strength: ☐ Functional ☐ Limited: ☐ See attached ROM and Strength assessment: *Summarize findings from strength assessment as clinically indicated*
Muscle Tone: ☐ Functional ☐ Hypotonic ☐ Hypertonic ☐ Fluctuating ☐ Flaccid
Skin Integrity: ☐ Functional ☐ Location(s) and type of current breakdown: *List location and staging of pressure ulcer(s).*
☐ Skin breakdown potential: *Describe any factors that may indicate potential for skin breakdown.*
☐ Edema present: *Describe type (e.g., pitting), severity and location of edema and how it is affected by or affects function (e.g. becomes worse and causes discomfort during prolonged sitting in mall classes).*
SEATING AND POSITIONING: ☐ Indicated ☐ Not indicated *Complete this section only if clinically indicated; if it is not indicated, check "not indicated" box and go to next section.*
Current supports: ☐ None ☐ List type, usage, adaptations: *List assistive technology systems and/or equipment (e.g. wheelchair for seating, positioning and mobility) as well as a description of type (e.g., standard make and model, custom), and schedule of use.*
Wheelchair assessment: ☐ Indicated ☐ Not indicated *Complete this section only if clinically indicated; if it is not indicated, check "not indicated" box and go to next section. If indicated, perform wheelchair assessment, mat assessment, simulation, as clinically appropriate.*
Observations: *Describe individual's sitting posture in current wheelchair or seating system, and/or individual's ability to access, propel and/or care for current wheelchair or seating system. Discuss results of simulation, including length of time in various positions, functional benefits and/or drawbacks of each position, and clinical observations (e.g. drop in O2 saturation, signs of individual discomfort or happiness). Provide clinical observations regarding laptray and armrest use (e.g., observed to have better fine motor control when using laptray for proximal arm support.)*
Bed positioning/Alternate positioning: ☐ Not indicated☐ Sidelying ☐ Quadraped on forearms ☐ Prone on forearms
☐ Other: *List any other devices utilized.*
Results: *If clinically indicated, assess individual for additional alternate positioning options. Discuss results, including length of time in various positions, functional benefits and/or drawbacks of each position, and clinical observations (e.g. drop in O2 saturation, signs of individual discomfort or happiness).*
Impact of alternate positioning on functional ability, participation and socialization: *Discuss the implications for alternate positioning on participation in daily activities and include a description on how each position facilitates and supports or limits functional performance (e.g., quadraped on forearms position provides proximal arm support to allow individual to participate in games requiring functional distal hand use; right elevated sidelying position is observed to be effective for helping to control reflux during sedentary leisure activities such as watching movies that occur after mealtimes).*
GROSS MOTOR FUNCTION: *For each item, check the most appropriate box and provide additional information as clinically indicated*
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

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

Mobility and Movement:

Mobility: ☐ Functional ☐ Needs assistance: *List all types of assistance needed to achieve maximum functional independence including devices, cueing, physical assistance, and/or environmental modification as well as any specific functional abilities that the individual may have (e.g., can walk short distance to dining room independently).*

Transfers: ☐ Functional ☐ Needs assistance: *List all types of assistance needed to achieve maximum functional independence including devices, cueing, physical assistance, and/or environmental modification as well as any specific functional abilities that the individual may have (e.g., can fasten and unfasten lapbelt on wheelchair independently, can use front wheeled walker and transition between sidewalk and grass surfaces).*

Quality of movement and motor control: *Describe the individual's coordination, smoothness and accuracy of movement patterns and impact on functional performance, as well as any observed difficulties with motor learning or recommended methods for motor learning (e.g., augmented feedback, modeling, massed practice) in order to improve functional performance.*

Endurance: ☐ Functional ☐ Limited: *List any limitations on endurance (e.g., decreased aerobic capacity, muscle fatigue) and how these limitations impact functional activities.*

Posture and Alignment: *Describe the individual's ability to attain and maintain posture in various positions tested and observed. Discuss observed alignment unsupported and with various levels and types of support as clinically indicated.*

Describe observed limitations in muscle tone and movement on attaining and/or maintaining alignment for optimal positioning. List any observed musculoskeletal limitations on attaining and/or maintaining alignment for optimal positioning.

Orthotic and Prosthetic Devices**:** *Check the most appropriate box and provide additional information as clinically indicated*

☐ Not indicated ☐ Indicated but not utilized ☐ In use or recommended: *List and describe UE or LE splints, prostetics, and/or orthotic devices, as well as use, schedule, and barriers to implementation (e.g., individual refuses to wear right AFO).*

FINE MOTOR FUNCTION: *For each item, check the most appropriate box and provide additional information as clinically indicated*

Hand Preference: ☐ Right ☐ Left ☐ No hand preference ☐ Unable to determine

Prehension patterns: ☐ Functional ☐ Limited: *Describe limitations in prehension patterns that impact functional performance and participation in preferred activities, as well as specific prehension patterns that the individual currently uses.*

Coordination and control of reach, grasp and release: ☐ Functional ☐ Limited: *List any limitations in fine motor strength and coordination (e.g., intention tremor, impaired voluntary release, overshooting of reach) and how these limitations impact functional performance and engagement in preferred activities.*

Bilateral and/or bimanual hand activity: ☐ Able to use two hands together for functional tasks ☐ Limited: *Discuss any difficulties with using both hands for functional tasks as well as any potential compensatory strategies that are or could be utilized to enhance functional engagement and independence.*

FUNCTIONAL MEALTIME AND DINING SKILLS: ☐ Indicated ☐ Not appropriate at this time

	Functional ability, level of assistance and supervision *List level of independence and any*	**Performance components, task demands, and environment, (including Triggers, Target behaviors)** *List performance components*	**Supports and/or techniques to promote safety and/or independence (Adaptive equipment; Special procedures and techniques;**

	specific functional abilities the individual exhibits during task performance	*that are problematic, clinical rationale for why performance is limited, as well as information regarding considerations and/or potential modification for task and environment*	**Individual and staff positioning)** *List level of staff physical assistance, type and frequency of verbal and touch prompts, individualized techniques for enhancing performance, adaptive equipment, and/or environmental modifications to improve engagement and independence*
Mealtime and Snacks			
Oral Hygiene			
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:

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Activities of Daily Living: Self Care ☐ Indicated ☐ Not appropriate at this time

	Functional ability, level of assistance and supervision *List level of independence and any specific functional abilities the individual exhibits during task performance*	**Performance components, task demands, and environment** *List performance components that are problematic, clinical rationale for why performance is limited, as well as information regarding considerations and/or potential modification for task and environment*	**Supports and/or techniques to promote safety and/or independence (Adaptive equipment; Special procedures and techniques; Positioning)** *List level of staff physical assistance, type and frequency of verbal and touch prompts, individualized techniques for enhancing performance, adaptive equipment, and/or environmental modifications to improve engagement and independence; include documentation that these supports are the* ***least restrictive*** *supports necessary to promote function and safety.*
Toileting			
Dressing and			

Grooming			
Bathing			
Other:			

Activities of Daily Living: Work, Education, Leisure and Instrumental ADL's: ☐ Indicated ☐ Not appropriate at this time

	Functional ability, level of assistance and supervision *List level of independence and any specific functional abilities the individual exhibits during task performance*	**Performance components, task demands, and environment (Environmental considerations)** *List performance components that are problematic, clinical rationale for why performance is limited, as well as information regarding considerations and/or potential modification for task and environment*	**Supports needed to promote independence (Adaptive equipment)** *List level of staff physical assistance, type and frequency of verbal and touch prompts, individualized techniques for enhancing performance, adaptive equipment, and/or environmental modifications to improve engagement and independence*
Work			
Education			
Leisure:			
Household chores			
Shopping			
Meal planning			
Money Management			

HABITS, ROLES AND ROUTINES: *List social roles required by the individual and discuss any dysfunction in fulfilling and participating in social roles. Discuss any recent role changes, as well as unhealthy habits and/or routines that limit functional performance and independence.*
ANALYSIS OF FINDINGS: ☐ Not indicated; please refer to Integrated Therapy Services Analysis of Findings

Individual's priorities and life goals: *Write a succinct and clinically meaningful description of the individual's life goals and/or the individual's goals in terms of enhancing functional performance and participation. List any aspirations, preferences, and/or motivating factors that may help with prioritizing evaluation and/or treatment.*

This information should ideally come from the individual, but if individual is psychologically unstable or unable to communicate goals and priorities, state the reason and document supplemental proxy information about individual's preferences from staff and/or family as clinically appropriate.

Present functional status summary: *Describe the individual's current functional status, including limitations, needs, and implications for engagement and participation in and independence with functional activities, roles, and routines. This should be an overall functional summary of the individual's status. Describe the individual's ability to attain and maintain a healthy balance of engagement in leisure, wellness and enrichment activities, in various settings and environmental contexts. Discuss the potential impact of current leisure habits and routines on psychosocial well-being and health, as well as skills needed to promote more independent functioning. Discuss the skills and supports that the individual needs to acquire in order to progress to the next level of care, meet personal goals, regain previous roles, attain new roles, and/or enhance quality of life. Prioritize goals and discuss rehabilitation potential and possible progression of treatment for recommended areas of functional performance and engagement.*

Environments, modalities, preferences, and/or strategies that support learning and/or performance or may hinder performance: *List any recommendations for strategies and supports such as therapeutic modalities (e.g., music), techniques (e.g., speaking slowly to allow additional time for auditory processing), environmental modifications (e.g., does best when sitting in the front of a treatment mall class so that visual distractions are minimized), identified during the evaluation or assessment that may promote learning, interest and/or compliance with interventions. List any barriers to participation in preferred therapeutic and leisure activities, as well as possible adaptations and modifications to enhance performance and independence (e.g., may be unable to see fine print and low contrast colors due to low vision; recommend large print books for reading and high contrast color [e.g., red] balls for kickball games, may be able to take turns if activities are graded and performed in small groups of two to four people that would limit wait time to two to three minutes in order to introduce and promote consistent rule adherence and game playing etiquette, may require verbal instructions and assistance reading handouts during didactic mall groups).*

Implications for Discharge Planning: *Discuss implications of current functional status on discharge planning options, as well as skills and supports that the individual may need to acquire to ensure optimal placement in the least restrictive and most beneficial setting. Transportation is very frequently an issue when planning for discharge and placing individuals in community programs so this information will help with d/c planning.*

Recommendations for additional assessments or evaluation: ☐None ☐ List: *List any recommendations for diagnostic tests (e.g., MBS, nerve conduction study), or further discipline specific assessments (e.g., psychological assessment) based on assessment or evaluation findings, and provide rationale and justification.*

Recommended Goal(s): *List the specific goal(s) recommended by assessment or evaluation findings that will help the individual attain discharge and/or recovery outcomes. The goal(s) should include 2 parts: 1. What the individual does or does not do or experience and 2. How this is known. Example: Mr. E. is unable to propel his wheelchair independently as evidenced by observation on the unit and in the Physical Therapy clinic.*

Recommended Objective(s): *List specific objectives that will support stated goals to facilitate discharge, recovery, and/or enhance quality of life. Objectives should be meaningful to the individual, tied to a functional skill or activity, observable and be written as S.M.A.R.T. (Specific, Measureable, Attainable, Realistic, and Time-bound) objectives that include the following 5 parts:*

1. *What will the individual do?*
2. *How will you know?*
3. *What is the performance criterion?*

4. How will you know that she has achieved the objective (termination criteria)?
5. Where will you find the documentation?

Example: Mr. E will exhibit independence with indoor mobility as evidenced by self-propelling his wheelchair independently from his room to the dining room for breakfast with one rest break for three consecutive days as documented in the interdisciplinary progress note.

Recommended Intervention(s): *List formal active interventions:*
These are interventions that are performed by staff to assist the individual in meeting stated goals and objectives, and should include the following 6 parts:

1. *Who will be responsible for providing the intervention?*
2. *What is the title of the intervention?*
3. *At what time and on which day(s) will the intervention take place?*
4. *Where will the intervention take place?*
5. *What will the provider teach?*
6. *Which of the individual's strengths will be used to help the individual achieve his or her treatment objectives?*

Example: Alicia Walker, PT will provide direct physical therapy treatment Monday through Friday from 7:30-8:00a.m. on Unit 23. Dr. Walker will provide therapeutic exercises to improve upper extremity strength and endurance, and teach energy conservation techniques using Mr. E.'s strength of wanting to be able to eat breakfast without waiting for staff to assist him to the dining room, so that he can engage in an enrichment activity before his morning treatment mall groups.

List service based treatment or supports (e.g. 24 Hour Support Plan) and milieu interventions as they relate to promoting attainment of the objective.
Example: Direct care staff will use the individualized 24 hour support plan to promote Mr.E.'s maximum functional independence with mobility and transfers throughout the day.

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Signature and date
Sign evaluation and list the date that the evaluation was finalized and completed.