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

NAME: _____
ADMISSION DATE: _____
ID#: _____

Name and type of evaluation(s) and/or assessments(s) used:

- ☐ Occupational Therapy Comprehensive Evaluation
- ☐ Physical Therapy Comprehensive Evaluation
- ☐ Speech Therapy Comprehensive Evaluation
- ☐ Swallowing and Mealtime Evaluation
- ☐ Assistive Technology Evaluation
- ☐ Standardized assessment(s): _____

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/evaluations: _____

Recommended Goal(s): _____

Recommended Objective(s): _____

Recommended Intervention(s): _____

_____
Signature and date

_____
Signature and date

_____
Signature and date

_____
Signature and date