HOME OCCUPATIONAL THERAPY SERVICES

Assessment within the home for active, safe and independent living

Patients Name:

Address:

Tel No:

Private health fund:

D.O.B:

Entitled card holder details:

Contact person/ No. :

Presenting Diagnosis/problems

PMHX:

Reason for referral:

- ☐ Home assessment
- ☐ Home rehab program
- ☐ Falls prevention
- ☐ Palliative care
- ☐ Post operative
- ☐ Homefront Safety Pro

Weight:

Heel – popliteal:

Falls Risk:

- ☐ Yes
- ☐ No

No. of falls /12 months

Social situation:

- ☐ Alone
- ☐ Spouse
- ☐ Family/friends

Accommodation:

- ☐ Private
- ☐ Rented
- ☐ Homes West

Care services:

- ☐ Nursing
- ☐ Domestic
- ☐ None

Social supports:

- ☐ Spouse
- ☐ Family/friends
- ☐ none

Current function

Transfers:

Shower

- ☐ Independent
- ☐ Assisted
- ☐ Dependent
- ☐ sit to shower
- ☐ h/shower
- ☐ rails
- ☐ commode

Bed

- ☐ Independent
- ☐ Assisted
- ☐ Dependent
- ☐ bedrail
- ☐ o/bed pole
- ☐ other

Chair

- ☐ Independent
- ☐ Assisted
- ☐ Dependent
- ☐ height adj chair
- ☐ electric recline
- ☐ other

Transfers (cont):

Toilet

- ☐ Independent
- ☐ Assisted
- ☐ Dependent
- ☐ OTF/raiser
- ☐ commode
- ☐ urinal
- ☐ rails
- ☐ continent
- ☐ incontinent
- ☐ catheter
- ☐ colostomy

Ambulation:

- ☐ Independent
- ☐ Assisted
- ☐ Dependent
- ☐ w/stick
- ☐ crutches
- ☐ w/frame
- ☐ seat walker
- ☐ w/c
- ☐ Full wt bear.

IADLS

Meal prep

- ☐ Independent
- ☐ Assisted

Medication Mgmt

- ☐ Independent
- ☐ Assisted

Transport

- ☐ Independent
- ☐ Assisted

Referring practitioner:

Provider number:

Contact details:

☐ Report required

Assessment required:

- ☐ Pre discharge
- ☐ Post discharge

Date of Discharge:

☐ Client is aware of cost (if applic)

Precautions

Medical:

Behavioural:

2-person visit required:

- ☐ Yes
- ☐ No

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