



Clinical Evals/Update Form

Member: _____ ID #: _____

Case Manager: _____ Phone #: _____ Ext: _____

Height: _____ Weight: _____

Diagnosis: _____ Co Morbidities: _____

Please Indicate:

Max Assist = Max Contact Guard Assist = CGA Independent = I Mod Assist = Mod

Supervision = S Min Assist = Min Modified Independent = MI

Therapy PT	Goal-	Initial Eval Date-	Date-	Date-	Date-
Bed Mobility					
Transfers					
Ambulation Gait Deviation					
Distance					
Assistive Device					
Stairs Steps to Enter					
Weight Bearing LB					
Strength LB					
Balance Stand Static Stand Dynamic					
Endurance					

Therapy OT	Goal-	Initial Eval Date-	Date-	Date-	Date-
Grooming					
UB bathing/dressing					
LB bathing/dressing					
Toileting Hygiene Transfer					
Balance Sit Static Sit Dynamic Strength UB					
Endurance					
Homemaking Skills					

What are current Barriers for DC (freq hosp readmits, new DX, ect-please explain):

Fall Risk: _____

Current Amount of Therapy:

PT _____ mins/day _____ days/week

OT _____ mins/day _____ days/week

Rehab Potential: _____

Time Frame needed to reach goals (date): _____

Additional Comments / Nurses Notes:

Patient Name: _____

Date: _____

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Therapy ST	Goal-	Initial Eval Date-	Date-	Date-	Date-
Swallowing					
Articulation					
Aphasia / Dysphasia					
Cognitive Abilities					
Vent					
Mode					
FIO2					
Peep / CPAP					
Pulse Ox					
HR					
Weaning					
Trach-Shiley #					
Freq of Suction					
Volume					
Color					
Consistency					
Weaning					
Lungs Sounds					
Neb Tx					

Current Amount of Therapy:

ST _____ mins/day _____ days/week

RT _____ mins/day _____ days/week

Trach / Vent Weaning: _____

Pain Management: _____

New / Changed Orders: _____

Patient / Family Teaching: _____

Patient Name: _____

Date: _____

IV's-

TPN: _____

IV Antibiotics: _____

Drug: _____

Dose: _____

Frequency: _____

Stop Date: _____

Access / Site: _____

Injectable Meds: _____

IM: _____

Sub Q: _____

Nursing	Goal-	Initial Eval Date-	Date-	Date-	Date-
Vital Signs					
Tube Feeding					
Date on Insertion					
Formula					
Rate					
Frequency					
Tolerance					
Residuals					
Amt of PO intake					
Target Rate					
Hemodialysis					
On Site					
Off Site					
BS Management					
BS Range					
Coverage					
Pt Ability to Do					
Teaching Needs					
Current Diabetic Meds					
Frequency of Accuchecks					
New Orders					
Pt Own Monitor					

Patient Name: _____

Date: _____

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Wounds	Goal-	Initial Eval Date-	Date-	Date-	Date-
Location					
Stage					
Size					
Exudate					
Odor					
TX Order					
TX Frequency					
Wound Clinic					
Wounds					
Location					
Stage					
Size					
Exudate					
Odor					
TX Order					
TX Frequency					
Wound Clinic					
Wounds					
Location					
Stage					
Size					
Exudate					
Odor					
TX Order					
TX Frequency					
Wound Clinic					
Wounds					
Location					
Stage					
Size					
Exudate					
Odor					
TX Order					
TX Frequency					
Wound Clinic					

Patient Name: _____

Date: _____