THERAPY HOME EVALUATION

Name:	Unit/Room:	DOB:	Age:
Medical Dx:		Onset Date:	
Treatment Dx:		MD Order: Y N N/A	

Reason for Eval / Re-eval:	Home Address / Directions:
Resident Prior Living Arrangements: (ie: alone, with spouse, home health, etc)	List Who Is Present For Evaluation:
Prior Level of Function (pre onset):	Past Medical Hx / Comorbidities:
Social Hx / Social Support - Both Physical and Cognitive:	Resident's Goals / D/C Plan:
Date Resident Last In The Home:	

SUBJECTIVE:

OBJECTIVE DATA:

See attached data collection sheet for information about each room the resident will be required to access,

Therapist _____ Date _____

Name: DOB:

ASSESSMENT OF FINDINGS:

Based on the data gathered, the following recommendations for discharge are made:

Equipment Needed: (DME)

Home Modifications Needed:

Home Services Recommended:

- ☐ Meals on Wheels
- ☐ Lifeline
- ☐ Home Care Services for: Nursing PT OT SLP Home Health Aide
- ☐ Other:

SUMMARY OF EVALUATION

THERAPY PLAN OF CARE

- ☐ Continue Rehab Services that are in place to progress toward discharge to community
- ☐ Follow-up Home Evaluation Required due to: _____
- ☐ Re-assess potential for discharge to community with Interdisciplinary Team
- ☐ Other:

_____

Therapist Date

I have reviewed the evaluation findings and certify the plan of care

Physician Signature / Date

THERAPY HOME EVALUATION - DATA COLLECTION / RECOMMENDATIONS			
ROOM	WILL RESIDENT NEED TO USE ROOM ON DC?	ROOM DETAILS	MODIFICATIONS NEEDED (EXPLAIN)
MAIN ENTRY			
LIVING AREA			
KITCHEN			
DINING AREA (IF NOT KITCHEN)			
BEDROOM			
BATHROOM			
UPPER LEVELS			
BASEMENT			
OTHER			