FOCUS ON FUNCTION
THERAPY EVALUATION AND PLAN OF CARE

PATIENT NAME:_____ DATE:_____

Safety Measures

- ❑ 24 hour supervision
- ❑ O2 Precautions
- ❑ Seizure Precautions
- ❑ Infection Control Precautions
- ❑ Up with help only
- ❑ Isolation Precautions
- ❑ Pacemaker Precautions
- ❑ Sharps Precautions
- ❑ Assistive Devices/ Fall Precautions
- ❑ Other _____

Nutritional Requirements/ Restrictions

- ❑ Regular
- ❑ Pureed
- ❑ Liquid
- ❑ Fluid Restriction_____ml
- ❑ Soft
- ❑ ADA _____Cal
- ❑ Na Restricted____gm
- ❑ Low Fat
- ❑ Low Protein

Functional Limitations

- ❑ Amputation
- ❑ Paralysis
- ❑ Legally Blind
- ❑ Bowel/Bladder
- ❑ Endurance
- ❑ Dyspnea w/min exertion
- ❑ Contracture
- ❑ Ambulation
- ❑ Hearing
- ❑ Speech
- ❑ Other (specify) _____

Activities Permitted

- ❑ Complete bedrest
- ❑ Partial wt bearing
- ❑ Wheelchair
- ❑ Bedrest BRP
- ❑ Independent at home
- ❑ Walker
- ❑ Up as tolerated
- ❑ Crutches
- ❑ No restrictions
- ❑ Transfer bed/chair
- ❑ Exercises prescribed
- ❑ Cane
- ❑ Other _____ _____ _____

Mental Status

- ❑ Oriented
- ❑ Forgetful
- ❑ Disoriented
- ❑ Agitated
- ❑ Comatose
- ❑ Depressed
- ❑ Lethargic
- ❑ Other _____

Allergies

- ❑ NKDA
- ❑ Drug(s)_____
- ❑ NKA
- ❑ Food/ Other_____

Medication Profile (Over)