ICE Case Study

ICE LEARNING CENTER
Occupational Therapy Initial Evaluation

Patient Name:
Patient ID #:
Age:

Date	Start Time	Location	Date of Onset	Rehab Diagnosis / Reason for Referral

Vital Signs	Precautions	Relevant PMH
	☐ Cleared for OT	

SUBJECTIVE

Complaints	Pain (Current) 0 1 2 3 4 5 6 7 8 9 10

Prior Level of Function, Support at Home	Home Situation	DME
	☐ Private home ☐ Apartment ☐ Assisted living ☐ Other______________________________ ☐ Stairs to enter ____________________ ☐ Stairs inside home_________________	☐ Standard walker ☐ Rolling walker ☐ 3-in-1 commode ☐ Tub seat / tub bench ☐ Splint / Sling ☐ Adaptive equipment ________________ ☐ Other _____________________________

Patient Goals

OBJECTIVE

Orientation / Cognition	Sensory Status ☐ Intact ☐ Impaired ☐ Absent	Visual Perception
Hand Dominance ☐ Right ☐ Left Affected Side ☐ Right ☐ Left ☐ Bilateral	Posture / Balance	Gross / Fine Coordination
AROM	PROM	Tone / Motor Control
Affected UE Function ☐ Nonfunctional ☐ Dependent Stabilizer ☐ Independent Stabilizer ☐ Gross Assist ☐ Semifunctional Assist ☐ Functional Assist ☐ Functional	Bed Mobility Sit to Stand Activity Tolerance / Endurance	Transfers: ☐ Bed →← to wheelchair ____________ ☐ Wheelchair →← Mat ____________ ☐ Toilet (standard) ____________ ☐ 3-in-1 commode ____________ ☐ Tub ____________ ☐ Other ____________

ADLs

Grooming / Hygiene	☐Independent	☐Supervision	☐Cueing	☐Contact Guard	☐Min A	☐Mod A	☐Max A	☐Dependent
UB Dressing	☐Independent	☐Supervision	☐Cueing	☐Contact Guard	☐Min A	☐Mod A	☐Max A	☐Dependent
UB Bathing	☐Independent	☐Supervision	☐Cueing	☐Contact Guard	☐Min A	☐Mod A	☐Max A	☐Dependent
LB Dressing	☐Independent	☐Supervision	☐Cueing	☐Contact Guard	☐Min A	☐Mod A	☐Max A	☐Dependent
LB Bathing	☐Independent	☐Supervision	☐Cueing	☐Contact Guard	☐Min A	☐Mod A	☐Max A	☐Dependent

IADLs
- ☐ Safety awareness
- ☐ Simple cooking task
- ☐ Light meal prep
- ☐ Complex meal prep

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Occupational Therapy
Initial Evaluation

☐ Homemaking
☐ Gardening
☐ Driving / Community mobility
☐ Work / education skills
☐ Other

ASSESSMENT

Patient is a _____ year old _______ referred to OT for

Strengths	Deficits	OT Indication ☐ Yes ☐ Trial ☐ No ☐ Justification:

Rehab Potential: ☐Excellent ☐Good ☐Fair ☐Guarded ☐Poor

PLAN

Short Term Goals

1. ______________________________ Time Frame:______________
2. ______________________________ Time Frame:______________
3. ______________________________ Time Frame:______________
4. ______________________________ Time Frame:______________
5. ______________________________ Time Frame:______________

Long Term Goals

1. ______________________________ Time Frame:______________
2. ______________________________ Time Frame:______________
3. ______________________________ Time Frame:______________
4. ______________________________ Time Frame:______________
5. ______________________________ Time Frame:______________

Frequency	Duration	Goals discussed with patient / caregiver ☐ Yes ☐ No (justification needed)
D/C Plan		End Date and Time:
Signature		License #

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