THERAPY SCREEN / REFERRAL

PARTNERS IN COMMUNICATION, INC

CLIENT NAME (Last, First): _____ FACILITY: _____

NAME / TITLE OF REFERRING AGENT: _____

	TO BE COMPLETED BY REFERRING AGENT	TO BE COMPLETED BY THERAPIST	
Functional Activity	**Observed Change / Deficit**	**Functional Limitations Not Indicated - Therapy Not Warranted**	**Functional Limitations Indicated - Therapy IS Warranted**
Ambulation / Gait			
Falls			
Upper / Lower Body Range of Motion			
Posture (sitting, standing)			
Strength (upper, lower extremity)			
Weight Change			
W/C mobility / use / equipment			
Sores / Wounds / Edema			
Weight Shifting			
ADLs (med. mgmt, phone use, meal prep., house/work duties, money mgmt)			
Balance (sitting, standing)			
Transfers / Bed Mobility			
Contractures (upper, lower extremity)			
Upper / Lower Body Dressing			
Grooming, Hygiene, Self-Care			
Coordination (fine, gross motor)			
Adaptive Equipment			
Sensory (seeking, defensiveness)			
Feeding			
Swallowing (coughing, choking, strangling, watery eyes)			
Expressing Personal Needs			
Speech			
Cognition (memory, judgment, safety awareness, initiation, attention)			
Hearing, Understanding Others			
Other:			

☐ Evaluation Recommended for: ☐ PT ☐ OT ☐ SLP

☐ Evaluation/Therapy Not Recommended at this time

Comments:

THERAPIST'S SIGNATURE & TITLE: X DATE: / /