GTA REHAB Network

FUNCTIONAL INFORMATION – Spinal Cord Injury

To be completed by Allied Health Team

Patient's Name:

Cause of injury:

Premorbid function: ☐ Independent in ADL ☐ Dependent in ADL

Comments: _____

Self Care:

Dressing: ☐ Independent ☐ Total assistance ☐ Partial assistance ☐ Supervision only

Bathing: ☐ Independent ☐ Total assistance ☐ Partial assistance ☐ Supervision only

Comments: _____

Swallowing: ☐ Intact, regular diet ☐ Dental soft diet ☐ Minced diet ☐ Pureed diet ☐ Thickened fluids

Comments: _____

Feeding: ☐ Independent ☐ Supervision required ☐ Partial assistance ☐ Total assistance ☐ Tube feed

Comments: _____

Transfers: ☐ Mechanical lift ☐ 2 person ☐ 1 person ☐ Supervision only ☐ Independent
☐ On bed rest

Comments: _____

Mobility aide: ☐ Standard Walker ☐ Rollator ☐ Wheelchair ☐ Cane ☐ Crutches
☐ 2 Wheeled Walker ☐ Other (specify)

Comments: _____

Wheelchair:

Requirements ☐ Manual ☐ Manual with tilt ☐ Power ☐ Power with tilt

Dimensions ☐ Hip width ☐ Upper leg length ☐ Lower leg length

Ambulation: ☐ Non-ambulatory ☐ 2 person ☐ 1 person ☐ Supervision only ☐ Independent
☐ Distance *(specify)* _____

Comments: _____

Limbs: ☐ Normal ☐ Left sided impairment ☐ Right sided impairment ☐ Bilateral impairment
☐ U/E impairment ☐ L/E impairment ☐ Impaired coordination ☐ Reduced strength
☐ Other _____

Comments: _____

FUNCTIONAL INFORMATION – Spinal Cord Injury (cont'd)

To be completed by Allied Health Team

Patient's Name:

Orthosis Type:

Collar	☐ Wear at all times	☐ When up in chair	☐ As needed	☐ Type	☐ Duration of use
Brace	☐ Wear at all times	☐ When up in chair	☐ As needed	☐ Type	☐ Duration of use
AFO	☐ Wear at all times	☐ When up in chair	☐ As needed	☐ Type	☐ Duration of use
Other splints	☐ Wear at all times	☐ When up in chair	☐ As needed	☐ Type	☐ Duration of use

Participation Level:

Specify: On average, patient is able to participate in _____ therapy sessions / day, _____times / week for _____minutes / session.

Sitting Tolerance ☐ Full ☐ Limit ☐ N/A ☐ Restrictions/ Duration _____

Communication:

Language expression: ☐ Intact ☐ Only able to express basic needs ☐ Uses gesturing ☐ Completely impaired

Language comprehension: ☐ Intact ☐ Follows basic instructions ☐ Impaired _____

Comments: _____

Cognitive Status:	Not Tested	Intact	Impaired
Attention	☐	☐	☐ *(specify):*
Able to follow instructions	☐	☐	☐ *(specify):*
Memory (short term)	☐	☐	☐ *(specify):*
Memory (long term)	☐	☐	☐ *(specify):*
Carry-Over/New Learning	☐	☐	☐ *(specify):*
Judgment	☐	☐	☐ *(specify):*
Insight	☐	☐	☐ *(specify):*
Other	☐	☐	☐ *(specify):*
MMSE Score: _____	☐	If did not/unable to complete, please explain:	

Briefly describe the rehabilitation goals *(Be specific — e.g. increased mobility, speech, community living skills, etc.)*

PT Progress & Plan

OT Progress & Plan

SLP Progress & Plan

Form completed by: (Include name/telephone/date)