GTA REHAB Network

FUNCTIONAL INFORMATION - CCC

To be completed by Allied Health Team

Patient's Name:

Premorbid function: ☐ Independent in ADL ☐ Dependent in ADL

Comments: _____

Alcohol Abuse: ☐ No ☐ Yes ☐ Episodic ☐ Active

Drug Abuse: ☐ No ☐ Yes ☐ Episodic ☐ Active

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

☐ Barium Swallow study done? ☐ No ☐ Yes Repeat Barium Swallow study required? ☐ No ☐ Yes Date:_____

Comments: _____

Transfers: ☐ Mechanical lift ☐ 2 person ☐ 1 person ☐ Supervision only ☐ Independent

☐ On bed rest

Comments: _____

Ambulation: ☐ Non-ambulatory ☐ 2 person ☐ 1 person ☐ Supervision only ☐ Independent

☐ Distance *(specify)* _____

Comments: _____

Mobility aide: ☐ Standard Walker ☐ Rollator ☐ Wheelchair ☐ Cane ☐ Crutches

☐ 2 Wheeled Walker ☐ Other (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 – CCC (cont'd)

To be completed by Allied Health Team

Patient's Name:

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:		

Does this patient have any long-term rehab goals? ☐ No ☐ Yes If yes, please specify below: *(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)