REQUEST FOR THERAPY SCREEN

DATE: _____/_____/_____

NAME: ____________________ MR#________

ROOM: ____________________

PHYSICIAN: ________________

PLEASE SCREEN:
(NURSING REQUEST)

☐ NEW ADMIT _________ Date

☐ RE-ADMIT _________ Date

☐ MDS _________ Date

☐ CHANGE IN STATUS

REASON FOR SCREEN

_____RECENT FALL
_____C/O MUSCULOSKELETAL PAIN
_____POOR BALANCE
_____WEAKNESS
_____IMPROPER USE OF WALKER
_____USES OBJECTS FOR SUPPORT
_____MUSCLE RIGIDITY

_____DIFFICULTY STANDING
_____FEARFUL OF WALKING
_____UNABLE TO CLIMB STAIRS
_____DIFFICULTY SITTING

_____INCREASED DEPENDENCE
_____C/O MUSCULOSKELETAL PAIN
_____HAND CONTRACTURES
_____WEAKNESS/DECONDITIONING
_____DIFFICULTY DRESSING
_____FREQUENT FOOD SPILLS WHILE EATING
_____TREMORS

_____UNABLE TO HOLD/LIFT OBJECTS
_____BED MOBILITY
_____DIFFICULTY WITH SELF-FEEDING/DRINKING
_____DECREASED W/C MOBILITY
_____ORIENTATION/COGNITIVE DEFICITS
_____LABILITY
_____TOILETING/HYGIENE DEFICITS
_____VISUAL PROBLEMS
_____AGITATION/BEHAVIORAL PROBLEMS

_____DIFFICULTY EXPRESSING WANTS/NEEDS
_____SPEECH IS DIFFICULT TO UNDERSTAND
_____SLOW TO RESPOND/RESPONDS INAPPROPRIATELY
_____DOES NOT UNDERSTAND WHAT IS SAID TO HIM/HER
_____PROBLEMS WITH READING/WRITING
_____ATTENTION SPAN DECREASED
_____POOR EYE CONTACT/OTHER POOR SOCIAL COMMUNICATION SKILLS
_____WEIGHT LOSS, FEEDING, SWALLOWING
_____COUGHING/CHOKING AT MEALS
_____POOR/DECREASING MEMORY SKILLS
_____DIFFICULTY PROCESSING/FOLLOWING DIRECTIONS

COMMENTS:

____

____

____

*Please indicate change in medical status

Signature: ________________________________

DATE SCREEN COMPLETED: _____/_____/_____

Therapist Comments: ____

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☐ THERAPY NOT INDICATED ☐ REFERRED TO RESTORATIVE ☐ THERAPY INDICATED

SIGNATURE: ____________________________ ☐ PT ☐ OT ☐ ST