Saint Elizabeth
Well beyond health care

Occupational Therapy Pediatric In-Home Assessment Form (school-age child)

Client Name _____ Date of Birth (dd/mm/yyyy) _____ Gender: ☐ Male ☐ Female

Therapist Name and Designation _____

Parent/Substitute Decision Maker name and contact info: _____

Functional Concern/Reason for Referral: _____

Funder ☐ LHIN (Visit Category:_____, Visit amount:_____) ☐ Self-Pay ☐ Other _____

☐ File reviewed ☐ Consent to Assess obtained ☐ Client Bill of Rights Reviewed ☐ OT Role explained ☐ Informed Consent Process Followed
☐ Consent to collect/disclose information reviewed & obtained ☐ Reason for referral reviewed with client &/or parent/s/legal guardian ERL code: _____ Not Assigned _____
☐ Two identifiers were used to confirm client's identity: ☐Client Name on ID ☐Parent/guardian verification ☐Other:

Parent and Child Interview (What is the most important goal I can help you with?) ☐ Refer to progress note/checklist for more details

Diagnosis and Medical History (Relevant Surgeries, Procedures, etc.) ☐ See referral/file for details

Medications: ☐no meds ☐more than 5 meds ☐meds change in past 3 months ☐more than 2 prescribers
☐ if yes to two or more meds review questions, parent directed to discuss Medication Reconciliation with child's physician/pharmacist
☐ parent provided a list of meds Meds:

Community Connections: ☐ N/A ☐ Children's Treatment Centre _____ ☐ Infant Development Program
☐ Private Therapy _____ ☐ Other (specify) _____

Other Persons Involved in Client's Care: ☐ Nurse ☐ Speech Language Pathologist ☐ Physiotherapist ☐ Other

Client Communication ☐ Verbal ☐ Non-Verbal ☐ English as a Second Language (ESL)
Communication Aids and Tools: ☐ N/A

Cognitive and General Developmental Status ☐ N/A

Ethnic, Spiritual, Linguistic, Values, Beliefs or Cultural Requests:
☐ Nurse ☐ Speech Language Pathologist ☐ Physiotherapist ☐ Other

SAFETY CONCERNS Note presence of following: ☐ Fire hazards ☐ Pet hazards ☐ Sharps ☐ Environmental hazards (mold, infestation, etc.)
Details:

PHYSICAL STATUS (WNL = Within Normal Limits WFL= Within Functional Limits)

	Not Assessed	WNL/WFL	**Details:** Specify possible functional implications, limitations
Muscle Tone (low/high/mixed)			
Range of Motion (functional vs contractures/limitations)			
Strength (Left/Right, U/E, L/E, grip strength)			
Postural Control (is added support needed?)			
Balance			
Gross Motor Skills			
Fine Motor Skills			
Skin Health (history, issues impacting skin breakdown)			Is the client at risk of skin breakdown? ☐ no ☐ yes If yes, Pediatric Braden Q Score: Details:
Pain			Location: Least pain: 1 2 3 4 5 6 7 8 9 10 :Most Pain
Hearing			
Vision			

Additional Details:

_____ _____ _____ _____
Therapist Name, Designation Initials Signature Date (dd/mm/yy)

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EQUIPMENT & FUNCTIONAL ASSESSMENT

MOBILITY ☐ Ambulatory ☐ Non-ambulatory ☐ Partially ambulatory Other:

	N/A	*Current* Equipment &/or Functional Status	Equipment &/or Support Needs
Mobility Aids and Equipment		☐ Walker ☐ Wheelchair ☐ Stander ☐ Positioning Devices Details:	
Stairs		☐ Independent ☐ Needs Assistance ☐ Dependent ☐ Uses Elevator/Lift	
Transfers ☐ Refer to lift and transfer form for more details		☐ Supervision and/or Set-up ☐ Assisted Transfers ☐ Lift Details:	☐ Transfer training is required ☐ Lift Training is required ☐ New/different equipment is required ☐ Education is required Details:
Bathing		☐ Set-up ☐ Supervision ☐ Assistance Positioning Needs: ☐ yes ☐ no	
Grooming		☐ Set-up ☐ Supervision ☐ Assistance Positioning Needs: ☐ yes ☐ no	
Eating		☐ Set-up ☐ Supervision ☐ Assistance Positioning Needs: ☐ yes ☐ no	
Toileting ☐ Continent ☐ Incontinent		☐ Set-up ☐ Supervision Required ☐ Assistance Required Positioning Needs: ☐ yes ☐ no	
Self-Care (personal hygiene, etc.)		☐ Set-up ☐ Supervision Required ☐ Assistance Required	
Sleep Habits		☐ Uses positioning devices ☐ Poor sleep routine ☐ Sensory issues ☐ Sleep impacted by physical status	
Dressing		☐ Set-up ☐ Cuing/Guidance ☐ Physical Assistance Required	
Managing Belongings		☐ Set-up ☐ Cuing/Guidance ☐ Physical Assistance Required	
PLAY		☐ Set-up ☐ Cuing/Guidance ☐ Physical Assistance Required	

ACCESSIBILITY

	N/A	Accessible	Problem &/or Safety Concern	Comments
Enter/Exit Home				
Emergency Plan				
Bedroom				
Bathroom				
Yard				
Kitchen				
Living spaces				
Other				

Additional Details:

Initials _____ Date (dd/mm/yy) _____

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Self-Regulation and Sensory Skills ☐ N/A ☐ Assess at later date

Sensory Screening (check all that apply)	☐ Suspected Sensory Difficulties Screening Method/s Used: ☐ Sensory Profile ☐ Sensory Processing Measure ☐ Observation ☐ Saint Elizabeth Tool ☐ Client/parent report ☐ Other:	**Relevant details:**
Possible Environmental &/or External Factors Impacting Sensory & Self-regulation Success (check all that apply)	☐ Lack of Equipment ☐ Possible lack of parent/client training to use equipment ☐ Inadequate space to use equipment ☐ Calm area needed ☐ Movement space needed ☐ Client can't physically access self-regulation space/equipment ☐ Possible visual over-stimulation ☐ Noisy home ☐ Possible lack of structure in child's day ☐ Lack of strategies ☐ Strategies in place but not being used effectively ☐ Other _____ ☐ Home set-up may not support client success, details _____ ☐ More support needed to help client access regulation strategies Details:	
Possible Client Factors Impacting Sensory & Self-regulation Success (check all that apply)	☐ Developmental readiness vs expectations ☐ Possible poor self-awareness ☐ Attention difficulties ☐ Communication delays ☐ Client having difficulty communicating sensory and self-regulation needs ☐ Client's physical limitations impact access to self-regulation strategies _____ ☐ Negative client behaviors are limiting access to strategies ☐ Habitual maladaptive regulation strategy ☐ Poor sleep habits/lack of sleep ☐ Other Details:	
Behavioral Concerns (reported &/or observed)		
Current Equipment and Strategies		

Treatment Planning: ☐ Sensory Strategies Needed ☐ Equipment Needed ☐ Education Needed ☐ Training Needed ☐ Space is Needed
☐ Further Assessment is required _____

Emotional & Mental Health (motivation, participation, peer relationships, attachment with family members, etc.)

Life-skills (comment on self-help and self-advocacy, level of independence with daily activities)

CLIENT STRENGTHS (client, caregiver, environmental qualities that may impact successful intervention, what is working well?)

Transition Planning ☐ N/A (will client/family be or has client been experiencing important or potentially difficult life transitions or transitions in care?)

☐ Transitions in care providers: specify _____ ☐ Transition to home from hospital care
☐ **Life transitions:** ☐ Change in school ☐ Change in living arrangement, specify: _____
☐ Transition from adolescent to adult living ☐ Significant recent change in medical status, specify _____
Details about changes and/or strategies to help with transitions:

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SUMMARY & CLINICAL IMPRESSION

Clinical resources therapist will use to develop intervention plan:
☐ Therapist Past Clinical Experience ☐ Research ☐ Best Practice Guidelines ☐ Practice Resources/Handouts ☐ Clinical Leadership Support
☐ Teamwork ☐ Other:_____

PLAN	Check "yes"	DETAILS/GOAL
If treatment plan is detailed in another report – specify:		
Equipment Needed		
Parent/Caregiver Training		
Environmental Modification		
Direct Intervention		
Parent Engagement &/or Meeting		
Client Advocacy		
Team Meeting		
Provide/Link with Resources		
Other		

Possible Barriers to Achievement of Goals: ☐ N/A ☐ Service Category Limitations ☐ Funding Limitations
☐ Lack of Support ☐ Lack of consent ☐ Difficulty engaging caregivers
☐ Client and caregiver preferences are different than proposed plan of care ☐ Other:_____
Details:

Informed Consent
Informed consent to treatment/plan of Care has been initiated with client and/or family: ☐ Yes ☐ No
Goals and Plan developed with input from client, family: ☐ Yes ☐ No: If no, why not?_____
Has the care plan been reviewed with the client? ☐ Y ☐ N ☐ N/A Family? ☐ Y ☐ N
Risks and benefits of intervention explained to client/family: ☐ Yes ☐ No

Service Model
Possible Service Category:_____ Number of visits available per service plan: _____
☐ Consultation ☐ Training ☐ Direct Intervention ☐ Combination Care Plan will meet funder service plan: ☐ Yes ☐ No ☐ N/A

Discharge planning discussion was initiated with client/family: ☐ Yes ☐ No

Additional Details:

Initials _____ Date (dd/mm/yy) _____