Physician Communication of Change in Resident Function

PHOENIX MOUNTAIN THERAPY

Patient Name: _____ Patient Phone Number: _____ DOB: _____

Physician Name: Audrey Bressor _____ Physician Phone Number: _____

Eating / Self Feeding	Cognitive	Physical Function
☐ Food falls out of mouth	☐ Difficulty following cues	☐ Decreased coordination
☐ Cannot or will not chew	☐ Difficulty with memory, sequencing, problem solving tasks	☐ Decreased functional activity tolerance
☐ Unable to cut food		
☐ Cannot lift utensils	☐ Unable to communicate needs	☐ Decreased leg ROM/strength
☐ Poor lip closure/drooling	**Grooming / Hygiene**	☐ Decreased arm ROM/strength
☐ Difficulty feeding self	☐ Difficulty bathing self	☐ Significant weight loss
☐ Food coming out of nose	☐ Unable to clean self after toileting	☐ Hand/arm/leg/foot contractures
☐ Unable to open containers	☐ Difficulty dressing	☐ Shakes or tremors
☐ Vomiting at/after meals or heartburn	☐ Difficulty combing hair, brushing teeth, or washing face	**Physiological Changes**
		☐ Swelling in
☐ Food residue in cheeks	**Posture**	☐ Pain in
☐ Coughing at/after meals	☐ Poor neck trunk control	☐ Skin breakdown in
☐ Difficulty swallowing medication	☐ Unable to sit upright in wheelchair	☐ Dizziness, vestibular, orthostasis
Transfers	☐ Difficulty looking to side	**Other Observations**
☐ Difficulty transferring	☐ Bends over while walking	
☐ Unable to move self in bed	**Safety**	
☐ Unable to get in/out of bed	☐ Frequent falls	
☐ Unable to get on/off toilet	☐ Balance loss sitting/standing	
Ambulation	☐ Decreased vision	
☐ Increased assistance with walking	☐ Poor safety awareness	
☐	☐ Poor technique with walker, cane, or wheelchair	
☐		

Communication to Physician

To prevent further decline and/or improve function, we are requesting orders for outpatient therapy to evaluate and treat for the following checked disciplines: ☐ PT ☐ OT ☐ ST

Below to be completed by physician (please complete all highlighted areas):

Orders to evaluate and treat for the above checked disciplines is: ☐ Approved ☐ Denied Date :

Physician Name/Signature: _____ Physician NPI: _____

Special instructions or additional information _____

_____

_____

FM21037B

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