THERAPY SERVICES

You have been provided with an illustrated home exercise program and have been advised to engage in these exercises post d/c. ☐ Yes ☐ No (explain)

EQUIPMENT ORDERED	COMPANY NAME / #	REASON	DELIVERY DATE/LOCATION

AREA OF FUNCTIONING	INDEPENDENT	*ASSISTANCE NEEDED	*DEPENDENT
Bed Mobility			
Transfer			
Locomotion			
Dressing			
Eating			
Toilet Use			
Personal Hygiene			
Bathing			
Ability to Communicate:			

OTHER/NOTES (Treatment Provided, Summary of Progress, Assistive Devices Needed, Lifestyle Changes)

Typed or Printed Name of Person Completing Section	Signature of Person Completing Section	Date