CVH-52
Rev 6/95

CONNECTICUT VALLEY HOSPITAL
PHYSICAL & OCCUPATIONAL THERAPY
HOME VISIT EVALUATION

[ ] General Psychiatry Division
[ ] Whiting Forensic Division
[ ] Addiction Services Division

Name _____

MPI# _____ *Print or Addressograph*

Ward/Unit_____Date of Admission_____ Date of Birth_____ Age _____ Onset _____

Physical Disability/Limitation: _____

_____

_____

Hand Dominance: [ ] Left [ ] Right

Discharge Site: [ ] SNF [ ] ICF [ ] Supervised Apartment [ ] Own Apartment [ ] Group Home
[ ] Home with family [ ] Home without family

1. ATTITUDE ABOUT RETURNING HOME (Family/ Patient's Comments): _____

_____

_____

_____

2. ENTRANCE TO HOME

Approach to the Building: [ ] Driveway [ ] Walk [ ] Grass [ ] Gravel
Which Doorway is not accessible: _____
[ ] Width [ ] Sill [ ] Door handle _____
Number of stairs: _____ Height of Steps _____
Are there handrail (s): [ ] Yes [ ] No If yes: [ ] Left [ ] Right [ ] Both sides
Are there other entrances that can be used: [ ] Yes [ ] No If yes, describe: _____

_____

Is construction of a ramp feasible: [ ] Yes [ ] No If yes, describe ramp recommendations
Additional comments: _____

_____

_____

_____

3. BATHROOM

Width of doorway: _____ [ ] Doorknob accessible [ ] Lights
Is there a doorsill: [ ] Yes [ ] No
Type of bathtub: [ ] Roll rim [ ] Square rim [ ] Wide square rim Height of rim _____
Shower: [ ] Yes [ ] No If yes; shower head: [ ] Yes [ ]No
Can a wheelchair get close to the: Sink [ ] Yes [ ] No Toilet [ ] Yes [ ] No Bathtub[ ] Yes [ ] No
Is the tub enclosed by: Shower curtain [ ] Yes [ ] No Sliding door [ ] Yes [ ] No
Is bathroom on the same floor as the : [ ] bedroom [ ] living room [ ] kitchen
Is it feasible to install handrails on: bathtub walls [ ] Yes [ ] No Toilet [ ] Yes [ ] No
Additional comments and equipment needs:_____

_____

_____

_____

4. BEDROOM

What floor is the bedroom on: _____ Width of the doorway: _____
Is there a doorsill: [ ] Yes [ ]No Height of the bed: _____ Type of bed: _____
Is the bed suitable for an attachment of: Side rails [ ] Yes [ ] No Trapeze bar [ ] Yes [ ] No
Can the furniture be arranged more conveniently: [ ] Yes [ ] No If yes, describe: _____
_____
Can the patient reach the closets: [ ] Yes [ ] No Remove and replace articles: [ ] Yes [ ] No
Can the patient reach the bureaus: [ ] Yes [ ] No Remove and replace articles: [ ] Yes [ ] No
Is there room for a wheelchair to maneuver: [ ] Yes [ ] No
Is there room for additional furniture: [ ] Yes [ ] No
Floor cover: _____
Additional comments: _____
_____
_____
_____

5. KITCHEN

Width of doorway: _____
Is there a doorsill: [ ] Yes [ ] No Is there room for movement of a wheelchair: [ ] Yes [ ] No
Are the cupboards within reach: [ ] Yes [ ] No
Can the patient remove articles from the top shelves: [ ] Yes [ ] No
Can the patient remove articles from the bottom cupboards: [ ] Yes [ ] No
Can the patient use kitchen utilities: Range [ ]Yes [ ] No Sink [ ] Yes [ ] No
Dishwasher [ ] Yes [ ] No Garbage Disposal [ ] Yes [ ] No Outlets [ ] Yes [ ] No
Is the dining table wheelchair height: [ ] Yes [ ] No
Is re-arrangement of the furniture feasible: [ ] Yes [ ] No
Can the patient transport items around the kitchen: [ ] Yes [ ] No
Would re-arrangement of work areas be helpful: [ ] Yes [ ] No If yes, describe: _____

Additional comments: _____
_____
_____
_____

6. OTHER ROOMS

Width of doorways: _____
Are there doorsills: [ ] Yes [ ] No Are the light switches in easy reach: _____
Would furniture re-arrangement be feasible: [ ] Yes [ ] No
Are there throw rugs to be moved: [ ] Yes [ ] No Is the telephone conveniently located: [ ] Yes [ ] No
Can the patient complete the following: Phone call [ ] Yes [ ] No Dial 911 [ ] Yes [ ] No
Answer a phone in a reasonable amount of time: [ ] Yes [ ] No
Are the hallways accessible: [ ] Yes [ ] No Width: _____ Floor covering: _____
Are there laundry facilities: [ ] Yes [ ] No Accessibility: _____
Additional comments: _____
_____
_____
_____

7. FUNCTIONAL ACTIVITES OF THE PATIENT

Can the patient enter and leave the home independently: [ ] Yes [ ] No If not, what assistance is required:

_____

Can the patient answer the doors: [ ] Yes [ ] No

Which transfer activities is the patient **UNABLE** to perform independently: [ ] Bed to wheelchair
[ ] Bathtub [ ] Chair to bed [ ] Shower [ ] Toilet [ ] Automobile

Are steps avoidable: [ ] Yes [ ] No Describe: _____

Elevator: [ ] Yes [ ] No Accessible [ ] Yes [ ] No Buttons [ ] Yes [ ] No
Emergency button [ ] Yes [ ] No

Outdoor accessibility: [ ] Yes [ ] No

Assessment *(Include patient response to treatment on re-assessment):*

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_____

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Recommendations and Discussion with Patient/Family:

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Assessment and Treatment Plan Discussed with Patient? [ ] Yes [ ] No *(Reason)* _____

_____

_____ _____

Date of Assessment Weather on date of Assessment

_____ _____

Signature/Title of Occupational Therapist Signature/Title of Physical Therapist