ENCORE REHABILITATION

NURSING TO THERAPY COMMUNICATION FORM

Please route to: (check all that apply): ☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Speech Therapy**

RESIDENT NAME _____ ROOM#_____

Seems to be experiencing a functional/situational change in the following area (s) that might benefit from specialized rehabilitation services:

- ☐ BATHING
- ☐ DRESSING
- ☐ PERSONAL HYGIENE
- ☐ TOILETING
- ☐ TRANSFERS
- ☐ BED MOBILITY
- ☐ AMBULATION
- ☐ W/C MOBILITY
- ☐ DISCHARGE PLANS
- ☐ BEHAVIOR/MOTIVATION
- ☐ RANGE OF MOTION
- ☐ ABILITY TO UNDERSTAND OTHERS
- ☐ MAKING SELF UNDERSTOOD
- ☐ MEMORY
- ☐ EATING, SWALLOWING
- ☐ SELF-FEEDING
- ☐ WEIGHT STATUS
- ☐ SKIN CONDITION
- ☐ SAFETY
- ☐ POSTURE
- ☐ ORIENTATION
- ☐ SPEECH
- ☐ VISION
- ☐ HEARING
- ☐ RESTRAINTS
- ☐ PAIN (NEW OR INCREASE IN C/O)

Please note your observations on these deficit areas: _____

_____

_____

_____ _____

Resident Care Coordinator/Nurse Signature Date

THERAPY FOLLOW UP-PLEASE RETURN THIS FORM TO THE RESIDENT CARE COORDINATOR/NURSE

The resident has been screened by:

☐	PHYSICAL THERAPY	Physical Therapist's Signature	Date
☐	OCCUPATIONAL THERAPY	Occupational Therapist's Signature	Date
☐	SPEECH THERAPY	Speech Therapist's Signature	Date