ENCORE REHABILITATION

Encore Rehabilitation Services

Therapy Screen Request

******To be completed by Family Member or Facility Personnel******

Resident:_____ Room #:_____

Please check all that apply:

_____ requires more help than before in **bathing, dressing**.

_____ is having more difficulty in **standing, walking, transfers, straightening arms and legs, stumbles, falls, can't sit upright, slides out of chair.**

_____ problems eating = **chokes, drools, doesn't chew food or holds food in mouth during meal or after.**

_____ has trouble feeding self = **drops utensils, can't see food, spills a lot.**

_____ has a **sudden weight loss or isn't eating as much.**

_____ has more difficulty **hearing, making needs known, remembering or understanding.**

_____ has areas of **redness or breakdown of skin.**

_____ has **outbursts, refuses treatment or medication, more confused**.

_____ other concerns: _____

_____

_____

_____

Please give this form to your Nurse

_____ _____
Signature of Family Member Date

_____ _____
Signature of Family Member Date

_____ _____
Signature of Family Member Date