OCCUPATIONAL THERAPY
HOME EVALUATION AND RECOMMENDATIONS

NAME: AGE:

EVALUATOR/ TITLE/ Contact Info: EVAL DATE:

LOCATION OF RESIDENCE:

RESIDENCE TYPE: APT ____ HOUSE ____ MOBILE HM.____

REFERRAL SOURCE: ***'s ISP Team REFERRAL DATE:

CONTACT PERSON: RELATIONSHIP: PHONE:

CONTACT PERSON: , Case Manager Ph#:

CLIENT PRESENT DURING EVALUATION? COMMENTS:

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SPECIAL ACCESSIBILITY ISSUES:

Diagnosis:

W/C ____ Walker ____ Gait Belt ____ Cane ____ (Specific Dimensions Attached if Needed)

Comments/ Description:

Approx. Surface Height Needed for Access in Sitting (uses wheelchair):

Transfers:

Vision Impairment: Hearing Impairment:

Bathing:

Env. Control:

Toileting:

Position for Eating:

Patio/ Porch/ Outdoor:

Other (As Related to Home Access):

Special Safety Issues:

Special Medical Issues:

Other (Include Known Parent/Guardian/Agency/IDT Concerns:

Other Residents in Household? :

Known Accessibility Concerns of Other Residents:

Anticipated Household Duties/Levels of Participation:

Laundry: Cleaning:

Cooking: Other:
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