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: