

REFERRAL TO RESTORATIVE

RESIDENT _____ ROOM # _____

DISCHARGE From: ___ PT ___ OT ___ ST TO: ___ Restorative ___ Maintenance

For:

<input type="checkbox"/> PROM	<input type="checkbox"/> Bed Mobility	<input type="checkbox"/> Dressing / Grooming	<input type="checkbox"/> Communication
<input type="checkbox"/> AROM	<input type="checkbox"/> Transfer	<input type="checkbox"/> Eating / Swallowing	<input type="checkbox"/> Bowel
<input type="checkbox"/> Splint / Brace	<input type="checkbox"/> Walking	<input type="checkbox"/> Amputation / Prosthesis	<input type="checkbox"/> Bladder

Current Functional Status: _____

Recommendations: _____

Assistive devices being used for ADL Performance, body alignment, splint or brace: _____

Ambulation: # feet _____ Assistive Device _____

Transfer: _____

___ Verbal Cues w stand by assist ___ weight bearing x 1 assist ___ Sit To Stand ___ Hoyer Lift

Weight Bearing Status: ___ None ___ Partial ___ Left ___ Right ___ Full

Precautions: _____

Goals: _____

Completed by: _____ Title _____ Date _____

I have been trained on the restorative program for this patient and will carry it out to the best of my abilities.

Training provided to:

Training provided by: _____ Title _____ Date _____