McLAREN FLINT

REHABILITATION TEAM CONFERENCE REPORT/IPOC

Rehab diagnosis/Impairments: ______________________________

Characteristics of intended DC environment: ______________________________

PHYSICAL THERAPY

Roll: Supine/L/R ______ Sit to supine: ______
Supine to sit: ______ Sit to stand: ______
Chair to chair transfer: ______ Car transfer: ______
Walking: ______
10 ft: Y / N Amt of assist needed: ______
10 ft on uneven surface: Y / N Amt of assist needed: ______
50 ft w/2 turns: Y / N Amt of assist needed: ______
150 ft: Y / N Amt of assist needed: ______
Stairs: ______
Amt of assist to go up 1 step (curb): ______
4 steps: ______ 12 steps: ______ Rails: ______
Balance: BERG: ______/56 N/A
Amt of PA to pick object up from floor while standing: ______
Expected primary mode of locomotion at DC: Walk / WC
-if WC or TBD test and score below:
Able to wheel 50 ft w/2 turns: Y / N Amt of assist: ______
150 ft: Y / N Amt of assist needed: ______

Weightbear status: No restriction Other: ______
Family Training: ______
Long term goal (to be met by discharge): ______
Short term goal (to be met by ______): ______
Recommended equipment: ______
Treatment plan (complete for initial team conference only):
☐ Bed mobility ☐ Transfer training ☐ Balance training
☐ Gait training ☐ Stair training ☐ WC management
☐ Neuromuscular re-education
☐ DME recommendations ☐ Therapeutic exercise
☐ Home exercise intruction ☐ Pt/family education
Comments: ______
ELOS: ______

PT Signature: ______
Date: ______ Time: ______

OCCUPATIONAL THERAPY

Eating: ______ Grooming: ______
Oral Hygiene: ______ Goal: ______
Bathing: UB ______ LB ______
Dressing: UB ______ LB ______
Footwear on/off: ______
Toilet Transfer: ______ Toilet Hygiene: ______
Tub/Shower Transfer: ______
Family Training: ______
Long term goal (to be met by discharge): ______
Short term goal (to be met by ______): ______
Recommended equipment: ______
Treatment plan (complete for initial team conference only):
☐ Bed mobility ☐ Transfer training ☐ Balance training
☐ Cognitive training ☐ Coordination training ☐ ADL training
☐ Visual/perceptual training ☐ Neuromuscular re-education
☐ Energy conservation/work simplification
☐ DME recommendations ☐ Therapeutic exercise
☐ Home exercise intruction ☐ Pt/family education
Comments: ______
ELOS: ______

OT Signature: ______
Date: ______ Time:

SPEECH THERAPY

Cognition/Language: ______
______
Swallow/Diet: ______
Education/training: Ongoing Completed With: Pt Family
Long term goal (to be met by discharge):
☐ Diet tolerance ☐ Cognitive linguistic ☐ Language
☐ Speech intelligibility ☐ Other: ______
Short term goal (to be met by ______): ______
Treatment plan (complete for initial team conference only):
☐ Language treatment ☐ Swallow treatment
☐ Cognitive linguistic ☐ Compensatory swallow strategies
☐ Therapeutic exercises ☐ Aspiration precaution education
☐ Diet mod/tolerance ☐ Home exercise instruction
☐ Speech intelligibility ☐ Pt/family eduation ☐ Other: ______
DC recommendations: ☐ Continue ST ☐ TBD
Anticipated level of supervision at DC:
☐ 24/7 (Direct Indirect) ☐ Intermittent ☐ Heavy intermittent
☐ Independent Comments: ______
Barriers to DC: ______
______

SLP Signature: ______
Date: ______ Time: ______

SOCIAL WORK/CASE MANAGEMENT

Discharge plan: ______
Barriers to DC: ______
______
Comments: ______

SW/CM Signature: ______
Date: Time: ______

PT.

MR.#/RM.

DR.

720b

NURSING

Bladder Continence
(check the one that best describes pt over last 3 days):
☐ Always continent ☐ Incontinent less than daily
☐ Incontinent daily (at least once)
☐ Always incontinent ☐ Stress incontenent only
☐ Not applicable (i.e. indwelling catheter)
☐ No urine output (i.e. renal failure, hemodialysis)
Bladder program: ______________________________
____
Comments: ____________________________________

Bowel Continence
(check the one that best describes pt over last 3 days):
☐ Always continent
☐ Occasionally incontinent (one episode)
☐ Frequently incontinent (2+ episodes, but at least 1 continent BM)
☐ Always incontinent (no continent BMs)
☐ Not rated (pt has ostomy or did not have BM in last 3 days)
Bowel program: ______________________________
____
Comments: ____________________________________

Skin Integrity (check all that apply):
☐ Skin intact At risk for breakdown Wound present
☐ Pressure ulcer: Stage ____ Location: _____________
☐ Surgical incision: Location _____________
☐ Other wounds: Location _____________
Describe: ____________________________________
☐ Wound care consulted Date: ________
☐ PEG present ☐ Trach present (size _____)
☐ Ostomy: Type ______________________________
☐ IV / PICC / Central line present (location: ___________)
Comments: ____________________________________

Nutritional Status
☐ NPO ☐ NGT ☐ PEG ☐ TPN ☐ Supplements
Appetite: ☐ Poor ☐ Fair ☐ Good
Diet: ☐ Reg ☐ Modified ☐ Diabetic ☐ Cardiac ☐ Renal ☐ Other
Liquids: ☐ Thin ☐ Thickened (specify _______________)
Comments: ____________________________________

Pain Management
Pain level: _______ Location: __________________
Interventions: _______________________________
Controlled: ☐ Yes ☐ No ☐ N/A

VTE Prophylaxis
☐ SCDs ☐ Antiembolic stockings (knee high/thigh high/ACE wrap)
☐ Anticoag therapy __________ ☐ Other: _____________
Comments: ____________________________________

Safety Awareness
Concerns: ____________________________________
Interventions: ________________________________
____

Other
IV Abx ☐ No ☐ Yes-reason: ________________ Stop date: ______
Sleep issues: _________________________________
Psychosocial: _________________________________

O2 ☐ No ☐ Yes - Liters: ___ ☐ N/C ☐ CPAP ☐ Trach ☐ Other
Dialysis ☐ No ☐ Yes Schedule ___________________
Comments: ____________________________________

Patient/Family Education/Training Initiated:
☐ Signs & sx of infection ☐ Medication education ☐ Safety ☐ Self-care deficit training ☐ Anticoagulants
☐ Diabetes education ☐ Positioning education ☐ Nutrition ☐ Loop recorder/life vest ☐ Skin/wound care
Precautions: ☐ Fall ☐ Aspiration ☐ Pacemaker ☐ Seizure ☐ Sternal ☐ Spinal ☐ Hip Other ___________
Comorbidity education: ☐ Afib ☐ CHF ☐ CKD ☐ CVA ☐ HTN ☐ PVD ☐ Diabetes ☐ Other __________
Comments: ____

RN Signature: ______________________________________ Date: _____________ Time: _____________

PHYSICIAN

Progress Assessment
Patient requires intensive Rehab program:
☐ PT _________ min _________ days/week
☐ OT _________ min _________ days/week
☐ ST _________ min _________ days/week
Special intensity/900 min/week
Anticipated LOS: __________________
Expected functional outcomes: ____________________
____
Comments: ______________________________

Short term goals: ☐ Met ☐ Partially met ☐ Not met
Home evaluation recommended: ______
Medical prognosis: ______________________________
Medical status/concerns: __________________________
____
Comments: ____________________________________
____
Physician/team recommendations: __________________
____

Discharge Plan:
Community setting: ☐ Home ☐ Assisted living ☐ AFC
☐ Alone ☐ Supervision ☐ Assist ☐ Intermittent ☐ 24/7
Institutional setting: ☐ SNF ☐ Acute hospital ☐ LTAC
24-hr caregiver availabe: ☐ No ☐ Yes Comments ________
Other: ____

Anticipated Follow UP Services:
☐ HHC ☐ OP therapy ☐ Not yet determined Services: ☐ PT ☐ OT ☐ SLP ☐ RN ☐ Aide ☐ MSW ☐ Other:

☐ IPOC: I have reviewed the above information and agree with the plan of care.
☐ I led and actively participated in this conference. I concur with all decisions made during this team conference.

Physiatrist Signature: ______________________________________ Date: _____________ Time: _____________

720b

PT.

MR.#/RM.

DR.