☐ Individual POC Team Conference
☐ Interdisciplinary/Family Conference

☐ Family Present
☐ Patient Present

McLaren Flint

REHABILITATION CONFERENCE REPORT

IMPAIRMENTS: _____

HOME ENVIRONMENT: _____

Feeding/ Grooming: _____
Bathing: _____
UE Dressing: _____
LE Dressing: _____
Tub Transfer: _____
Shower Transfer: _____
Toilet Transfer: _____
Toileting: _____
Family Training: _____
Equipment: _____
Comments: _____
LTG: _____
STG: _____

OT Signature: _____

Bed Mobility: _____
Transfers: Sit < > Stand: _____
Pivot: _____
Car Transfer: _____
Ambulation: _____
Stairs: _____
Balance: _____
W/C Mobility: _____
Wt. Bearing Status: _____
Family Training: _____
Equipment: _____
Comments: _____
LTG: _____
STG: _____

PT Signature: _____

Swallow/Diet: _____

Cognition/Language: _____

Education/Training: _____

LTG: _____
STG: _____

ST Signature: _____

Psychosocial Issues: _____

D/C Plans: _____

Barriers to D/C: _____

Patient Goals: _____

SW Signature: _____

Home Evaluation: _____

Out-Trip Appropriate: ☐ Yes ☐ No
Suggested Out-Trip: _____

PT.

MR.#/RM.

DR.

McLaren Flint

REHABILITATION CONFERENCE REPORT

Pain: _____

Bowel/Bladder: _____

Skin/Wound: _____

Diet: _____

IV: _____

O2: ☐ Yes ☐ No Liters: _____

Dialysis: ☐ Yes ☐ No

Medical Issues: _____

Safety/Alarms: _____

Education/Training: _____

Comments: _____

_____

Day RN Signature: _____

Pain: _____

Bowel/Bladder: _____

Change in Status: ☐ Yes ☐ No

O2: ☐ Yes ☐ No Liters: _____

☐ CPap ☐ BiPap

Sleep: _____

Medical Issues: _____

Safety/Alarms: _____

Education/Training: _____

Comments: _____

_____

_____

Night RN Signature: _____

Activity Involvement: _____

_____

Meal Prep Involvement: ☐ Yes ☐ No

CTRS Signature: _____

Physician/ Team Recommendations: Interdisciplinary Team Met

Patient requires intensive program or PT ____ OT ____ ST ____ hours per day / 5-7 days per week

Expected Functional Outcomes: _____

_____

Medical: _____

_____

Comments: _____

_____

Medical Prognosis: _____ ELOS: _____

Supervision: ☐ None ☐ Intermittent ☐ 24 hour D/C to: _____

STG Met: ☐ Met ☐ Not Met ☐ Partially Met: _____

D/C Follow Up: _____

Physician Signature: _____ Date: _____ Time: _____

REHABILITATION CONFERENCE REPORT

PT.

MR.#/RM.

DR.