

## NURSING TO THERAPY COMMUNICATION FORM

Resident: \_\_\_\_\_

Room #: \_\_\_\_\_

Physician: \_\_\_\_\_

Date: \_\_\_\_\_

### NURSING REQUEST

#### Physical Therapy

- \_\_\_\_\_ Decreased coordination
- \_\_\_\_\_ Decreased functional act tol
- \_\_\_\_\_ Decreased lower body ROM
- \_\_\_\_\_ Decreased lower body strength
- \_\_\_\_\_ Falls or slips forward/side
- \_\_\_\_\_ Frequent falls
- \_\_\_\_\_ Gait, shuffled
- \_\_\_\_\_ Gait, unsteady
- \_\_\_\_\_ Balance loss walking
- \_\_\_\_\_ Balance loss sitting/standing
- \_\_\_\_\_ Shortness of breath
- \_\_\_\_\_ Lower body contractures
- \_\_\_\_\_ Needs assistance with transfers
- \_\_\_\_\_ Needs assistance with walking
- \_\_\_\_\_ Pain in lower extremities
- \_\_\_\_\_ Poor neck/trunk control
- \_\_\_\_\_ Poor safety awareness
- \_\_\_\_\_ Poor sitting balance
- \_\_\_\_\_ Restraints
- \_\_\_\_\_ Shakes or has tremors
- \_\_\_\_\_ Skin breakdown
- \_\_\_\_\_ Swelling
- \_\_\_\_\_ Unable to get in/out of bed
- \_\_\_\_\_ Unable to get in/out of w/c
- \_\_\_\_\_ Leg splint causing redness

#### Occupational Therapy

- \_\_\_\_\_ Cannot lift utensils
- \_\_\_\_\_ Unable to open containers/pour
- \_\_\_\_\_ Unable to cut food
- \_\_\_\_\_ Difficulty feeding self
- \_\_\_\_\_ Visual problems
- \_\_\_\_\_ Does not look left/right
- \_\_\_\_\_ Decreased upper body strength
- \_\_\_\_\_ Limited upper body ROM
- \_\_\_\_\_ Poor trunk/neck control
- \_\_\_\_\_ Hand/wrist splint with redness
- \_\_\_\_\_ Upper body contractures
- \_\_\_\_\_ Difficulty grooming/hygiene
- \_\_\_\_\_ Difficulty dressing
- \_\_\_\_\_ Difficulty bathing
- \_\_\_\_\_ Unable to get in/out of bed
- \_\_\_\_\_ Unable to get in/out of w/c
- \_\_\_\_\_ Unable to get on/off toilet
- \_\_\_\_\_ Disoriented
- \_\_\_\_\_ Poor problem-solving skills
- \_\_\_\_\_ Poor safety awareness/judgment
- \_\_\_\_\_ Unable to follow directions
- \_\_\_\_\_ Decreased attention
- \_\_\_\_\_ Decreased memory
- \_\_\_\_\_ Difficulty propelling w/c
- \_\_\_\_\_ Unable to sit upright in w/c
- \_\_\_\_\_ Has shortness of breath
- \_\_\_\_\_ Decreased functional act tol

#### Speech Therapy

- \_\_\_\_\_ Cannot or will not chew
- \_\_\_\_\_ Food falls out of mouth
- \_\_\_\_\_ Food and/or liquid coming out nose
- \_\_\_\_\_ Pockets food in cheeks
- \_\_\_\_\_ Poor lip closure/drooling
- \_\_\_\_\_ Wet, gurgly voice
- \_\_\_\_\_ Coughing during/after meals
- \_\_\_\_\_ Vomiting during or after meals
- \_\_\_\_\_ Heartburn
- \_\_\_\_\_ History of hiatal hernia
- \_\_\_\_\_ Increased mucous or phlegm
- \_\_\_\_\_ Recurrent pneumonia
- \_\_\_\_\_ Non-oral feedings
- \_\_\_\_\_ Recurrent temperature spikes
- \_\_\_\_\_ Significant weight loss
- \_\_\_\_\_ Dehydration
- \_\_\_\_\_ Difficulty speaking
- \_\_\_\_\_ Unable to indicate wants/needs
- \_\_\_\_\_ Frequently asks speaker to repeat

Date(s) of Nursing documentation showing a decline or improvement in function \_\_\_\_\_

Nursing Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### THERAPIST RECOMMENDATIONS

\_\_\_\_\_ Therapy Screen completed  
\_\_\_\_\_ Reason Therapy screen not completed: \_\_\_\_\_

\_\_\_\_\_ PT Orders requested      \_\_\_\_\_ OT Orders requested      \_\_\_\_\_ ST Orders requested

\_\_\_\_\_ Nursing to request Therapy Orders

#### THERAPY PROGRAM INDICATED

- |                                     |                              |                              |
|-------------------------------------|------------------------------|------------------------------|
| _____ Rehab Dining                  | _____ ADL                    | _____ Communication          |
| _____ Balance/Falls Management      | _____ Dementia Management    | _____ Wound Management       |
| _____ Restraint Reduction           | _____ Cognitive Training     | _____ Low Vision             |
| _____ Positioning/Contracture Mgmt. | _____ Gait/Transfer Training | _____ Continence Improvement |
| _____ Activities Programming        | _____ Dysphagia              | _____ Pain Management        |

Therapy Signature: \_\_\_\_\_

Date: \_\_\_\_\_