

V. **FUNCTIONAL ASSESSMENT** (to be completed by professional who knows the patient/resident best): First assess person's functional level as either independent or dependent/requiring partial assist compared to others in the age group. If the person is dependent/partial assist, then determine whether the person needs and/or may benefit from training (as opposed to short term therapy) – i.e. working in a step-wise manner to achieve/maintain goals(s) for independence using specialized techniques generally used for educating/training persons with developmental disabilities/intellectual disabilities.

	INDEPENDENT	DEPENDENT OR REQUIRING PARTIAL ASSIST MAY BENEFIT FROM TRAINING?	
		YES	NO
SELF-CARE/PERSONAL CARE:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to perform necessary steps involved in bowel/bladder elimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to dress and undress self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to groom and complete personal hygiene needs as bathing, brushing teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to drink fluids, chew, and swallow foods and use utensils to feed self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICATION:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to understand and follow simple directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to communicate one's basic needs and wants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can verbally communicate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is non-verbal – uses gestures and some single words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COGNITIVE/SOCIAL:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to retain and recall what has been learned or experienced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to respond appropriately to visual or auditory stimuli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to make choices with little or no direction from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to choose, initiate, and engage in leisure activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to evaluate, use logic to discriminate/generalize situations and viable solutions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to discriminate gender similarities/differences and appropriate social/sexual behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to relate to others on a 1:1 or group basis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MOTOR ABILITIES/MOBILITY:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to perform coordinated gross motor activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to perform coordinated fine motor activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to perform eye-hand coordinated activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to independently use available transportation to get to desired destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to independently move from place to place in a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VOCATIONAL:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to adapt to changes in job related situations (peers, supervisors, assignments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to demonstrate appropriate and acceptable job specific skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to demonstrate responsible work related behaviors as attendance, work on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INDEPENDENT LIVING SKILLS:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to perform independent living household activities as budgeting, shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to monitor own health status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to administer own medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to schedule medical appointments and follow-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to monitor own nutritional status, including making meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NEEDS ADAPTIVE DEVICES TO PERFORM ANY/ALL OF THE ABOVE: SPECIFY
(e.g. prosthesis, orthosis, hearing aid, visual aid, communication device)

VI. EXTERNALIZING AND INTERNALIZING BEHAVIORS(S):	FREQUENCY (specify day/week/mo.)	MILD	MOD	SEVERE
Physical violence against others		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damage to property		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually inappropriate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-abusive		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse of unauthorized substances		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VII. **PSYCHOSOCIAL EVALUATION:** Current living arrangements, medical and support system

Name of Examining Physician

Signature of Physician

Date