

Gross Motor Assessment

<p>Bed Mobility/Transfers <u>Rolls</u> <input type="checkbox"/> Independent <input type="checkbox"/> min assist <input type="checkbox"/> mod assist <input type="checkbox"/> max assist <input type="checkbox"/> dependent <u>Supine-sit</u> <input type="checkbox"/> Independent <input type="checkbox"/> min assist <input type="checkbox"/> mod assist <input type="checkbox"/> max assist <input type="checkbox"/> dependent <u>Sit-stand</u> <input type="checkbox"/> Independent <input type="checkbox"/> min assist <input type="checkbox"/> mod assist <input type="checkbox"/> max assist <input type="checkbox"/> dependent Equipment used: _____ <u>Transfers</u> <input type="checkbox"/> Independent <input type="checkbox"/> min assist <input type="checkbox"/> mod assist <input type="checkbox"/> max assist <input type="checkbox"/> dependent _____ Equipment used: _____ Observations:</p>	<p>Sitting Posture <u>Head Position:</u> <input type="checkbox"/> midline <input type="checkbox"/> rotated R/L <input type="checkbox"/> flexed <input type="checkbox"/> extended <input type="checkbox"/> laterally flexed R/L <input type="checkbox"/> unable to hold independently <u>Arm Positions:</u> <input type="checkbox"/> normal <input type="checkbox"/> forward <input type="checkbox"/> arms to side <input type="checkbox"/> arms on legs <input type="checkbox"/> other _____ <u>Trunk Position:</u> <input type="checkbox"/> neutral <input type="checkbox"/> flexed <input type="checkbox"/> extended <input type="checkbox"/> scoliosis <input type="checkbox"/> leans R/L <u>Pelvic Position</u> <input type="checkbox"/> neutral <input type="checkbox"/> obliquity <input type="checkbox"/> sacral sitting <input type="checkbox"/> weight shifted R/ L <u>Leg Positions:</u> <input type="checkbox"/> ring sitting <input type="checkbox"/> side sitting <input type="checkbox"/> long sitting <input type="checkbox"/> short sitting Observations:</p>
<p>Standing/Gait <u>Stands</u> <input type="checkbox"/> Independent <input type="checkbox"/> min assist <input type="checkbox"/> mod assist <input type="checkbox"/> max assist <input type="checkbox"/> dependent <u>Gait Pattern</u> <input type="checkbox"/> heel toe <input type="checkbox"/> shuffled step <input type="checkbox"/> tip toe <input type="checkbox"/> crouched <input type="checkbox"/> scissoring <input type="checkbox"/> other _____ <u>Arm position</u> <input type="checkbox"/> arm swing <input type="checkbox"/> fixed <input type="checkbox"/> other _____ <u>Leg position</u> <input type="checkbox"/> normal <input type="checkbox"/> knees flexed <input type="checkbox"/> knees hyperextended <input type="checkbox"/> abducted <input type="checkbox"/> adducted <input type="checkbox"/> externally rotated <input type="checkbox"/> internally rotated <u>Foot /ankle position</u> <input type="checkbox"/> normal <input type="checkbox"/> pronated <input type="checkbox"/> supinated <input type="checkbox"/> tip toe <u>Trunk</u> <input type="checkbox"/> normal <input type="checkbox"/> neutral <input type="checkbox"/> flexed <input type="checkbox"/> extended <input type="checkbox"/> shifted R/L <u>Distance</u> _____ <u>Equipment used</u> <input type="checkbox"/> walker <input type="checkbox"/> crutches <input type="checkbox"/> cane <input type="checkbox"/> other _____ Observations:</p>	<p>Gross Motor Checklist tested/parent report <input type="checkbox"/> Rides a bike 5-6 yrs <input type="checkbox"/> Balances on one foot time: (R) _____ (L) _____ <input type="checkbox"/> Catches small ball: with 2 hands (5yrs) <input type="checkbox"/> with 1 hand (6yrs) <input type="checkbox"/> Broad jump (5yrs) distance: _____ <input type="checkbox"/> Skips with both feet (6yrs) <input type="checkbox"/> Walks downstairs with alternating feet (5yrs) <u>Running:</u> distance: _____ speed: _____ sec. pattern: _____ Observations/Activities/Likes/Dislikes/Met milestones on time:</p>

Standardized Assessments: yes no tool _____

Comments: _____

Gross Motor skill level is: Age appropriate Below age level _____

ASSESSMENT:

Strengths: _____

Needs / concerns: _____

Summary: _____

Patient/Family Education * Family not present
 Taught: * Patient-Family * Other _____
 Topic: * Reviewed Precautions * Other _____
 Method: * Demonstration * Explanation * Handout * Interpreter * Cyracom _____
 Learning barriers: * None * Cognitive * Literacy * Emotional * Language/Cultural * Poor Motivation _____
 * Motivation * Sensory * Other _____
 Response: * Understands / Demonstrates * needs review * No evidence of learning _____

PLAN

* Patient has no acute PT needs. Orders will be completed
 * Patient will be seen by PT 1-3x/ 2-4x / 3-5x / 4-6x a week for _____ weeks
 * Consults recommended OT * yes * no SLP * yes * no
 Goals: * Goals were * were not discussed with family
 Family Goals: _____
 If not, why? _____

Goals to be reviewed in one week

SHORT-TERM GOALS

LONG-TERM GOALS

Discharge Plan: Undetermined Acute to acute transfer acute to rehab transfer Home Health PT Outpatient PT School PT No F/U
 PT needs

I approve of this plan of care signature/pic

Signature/Title _____ Pic# _____ Date _____ Time _____