PDPM CHECKLIST FOR EVALUATING THERAPISTS

Patient Name:	**Therapist Name:**	**Date:**

PT	**Y/N**	**Source: H&P, eval/subjective, family interview**
SOB lying flat		
SOB after exertion		
Oxygen		
Splints/braces/TLSO		
Weight bearing restriction (UE or LE)		
BLE weakness		
Wounds		
Compression hose		

OT		
Complaints of visual deficits and/or glasses		
Colostomy		
Foley catheter		
Personal Mobility Device (pwc)		
Foot health (skin, toenails, heels, dry/cracked)		
Low Grip Strength		
BUE weakness		

SLP		(Add any to precautions box on eval)
Loss of liquid/solids from mouth when eating or drinking		
Holding food in mouth/cheeks or residual food after meals		
Coughing/choking during meals or swallowing meds		
Discomfort/pain/difficulty with swallowing		
CVA related apraxia, speech/language deficits or dysphagia		
Aphasia		