Resident Name: Meeting Date:

Interdisciplinary Team Meeting Data Collection

{Questions Specifically for Care Partners and Facility Staff}

What are your primary concerns?

How long ago did you notice these reported changes?

How much assist did the patient require with the following activities at home?

- **Bathing**
- **Dressing**
- **Grooming**
- **Hygiene**
- **Eating**
- **Ambulation**
- **Transfers**

Did the patient use any adaptive equipment or devices at home?

How often was the patient able to tolerate getting out of the house and for how long?

Has this patient ever been in a skilled nursing facility before? When and why?

Resident Name: Meeting Date:

Has this patient ever received OT services before? Where, when, and why?

What does this patient like to be called?

How has the patient been tolerating this setting so far?

What is the ultimate goal/plan (ie. to return home or transition to long-term care)?

What are you hoping therapy services will achieve?

{insert some Occupational Profile questions here or schedule time to complete profile}

Therapy Recommendations made during this meeting: