THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER

SELF REPORTED SCREENING FOR OCCUPATIONAL AND PHYSICAL THERAPY REFERRALS

Patient Name: _____ MDACC#:_____ Date _____
Local Phone #: _____
Have you had any occupational or physical therapy in this past year? _____
Physician: _____

*A **occupational therapist** is a professional who can address issues of activities of daily living such as dressing, bathing, eating, hand function, home management and safety.*
*A **physical therapist** is a professional who can address issues such as weakness, loss of balance or coordination, difficulty walking and moving, sensory changes and pain.*

Problems in any of the following areas are indications for intervention by occupational or physical therapy. Please go through the following checklist and indicate any areas in which you are having any difficulties.

FEEDING	**GROOMING**
❑ Difficulty getting food to my mouth	❑ Poor oral hygiene and/or inability to use my toothbrush correctly
❑ Inability to get food on a utensil or cutting food	❑ Difficulty combing hair, washing face and/or hands
❑ Inability to grasp utensil or handle food with fingers	**TOILETING**
MOBILITY	❑ Difficulty getting on/off the toilet or bedside commode
❑ Any falls within the last 2 months?	❑ Difficulty reaching parts of my body
❑ Normal activities are limited by lack of endurance/energy (i.e. standing while grooming; chores, etc.)	**DRESSING**
❑ Inability to transfer in and out of the tub or shower.	❑ Difficulty with taking on/off shoes and socks and/or lacing shoes.
❑ Not able to change positions in bed or need help getting out of bed	❑ Difficulty with upper body dressing (i.e. shirts, bra, buttons, etc.)
SAFETY	❑ Difficulty with lower body dressing (i.e. zipper, pants etc.)
❑ Inability to get through doorways or to the telephone	**HOMEMAKING**
❑ Need equipment to assist with safely participating in daily activities	❑ Inability to prepare my own meals
ARM/HAND FUNCTION	❑ Inability to drive myself
❑ Difficulty with handling small objects (i.e. dial telephone, light switch, jewelry, etc.)	❑ Physically unprepared to return to work
❑ Decreased feeling in hands	**LEG/FOOT FUNCTION**
❑ Problems with moving my arms and/or problems with arm strength	❑ Problems with moving legs and/or problems with leg strength
❑	❑ Difficulty getting up from a chair or bed
❑	❑ Uneven/unsteady walking

PLEASE LIST ANY OTHER ACTIVITIES THAT ARE LIMITED AT THIS TIME: _____

Call Rehab Services (713) 792-3192 for more information.