

Nursing Therapy Communication Change of Status Form (CENTURY)

Resident:

Description: Other

Date: 11/5/2025 13:30

Section Status: Signed

Lock Date: 11/6/2025 08:50

SECTION A. Nursing

<p>1. Physical Therapy</p>	<p>1. Physical Therapy Changes have occurred in the following areas <input type="checkbox"/></p> <ul style="list-style-type: none"> <input type="checkbox"/> 1. Ability to Walk (increase assistance, decrease distance) <input type="checkbox"/> 2. Transfer/Bed Mobility <input type="checkbox"/> 3. Frequent Falls <input type="checkbox"/> 4. Balance/Safety Awareness <input type="checkbox"/> 5. Pain <input type="checkbox"/> 6. Decrease in Lower extremity Range Of Motion <input type="checkbox"/> 7. Other
<p>2. Occupation Therapy</p>	<p>Occupational Therapy</p> <p>1. Occupational Therapy Changes have occurred in the following areas <input type="checkbox"/></p> <ul style="list-style-type: none"> <input type="checkbox"/> 1. ADL Self Performace (feeding, UB/LB dressing, grooming/hygiene) <input type="checkbox"/> 2. Toilet Transfer <input type="checkbox"/> 3. Wheelchair Mobility (self propulsion, turning, in/out doors, locking/unlocking, safety) <input type="checkbox"/> 4. Decreased in Upper Extremity Range Of Motion <input type="checkbox"/> 5. Bed and/or Wheelchair positioning <input type="checkbox"/> 6. Toileting (clothing management/hygiene) <input type="checkbox"/> 7. Other
<p>3. Speech Therapy</p>	<p>1. Speech Therapy Changes have occurred in the following areas <input type="checkbox"/></p> <ul style="list-style-type: none"> <input type="checkbox"/> 1. Ability to Speak (unable to indicate wants/needs, word finding difficulty, increase confusion, frequently asking speaker to repeat self) <input type="checkbox"/> 2. Following Commands, Sequencing <input type="checkbox"/> 3. Signs /Symptoms of Dysphagia (wet/gurgling speech, coughs with liquids/solids, drooling, pockets food in cheeks, food/liquid coming out of nose, vomiting during/after meals, increase time to eat meals) <input type="checkbox"/> 4. Oral Weakness (poor lip closure, decrease chewing ability, increase chewing time) <input type="checkbox"/> 5. Lack of Teeth <input type="checkbox"/> 6. Non-Oral Feedings <input checked="" type="checkbox"/> 7. Other <p>2. Therapy Other <input type="checkbox"/></p> <p><input type="text" value="d/t varied intakes/weight loss/decreased attention to task"/></p>

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Previous Section Cancel

SECTION B. Therapy

2. Therapy	FOR REHAB DEPARTMENT TO COMPLETE
	1. Therapy Screen H
	<input type="checkbox"/> a. PT Screen
	<input type="checkbox"/> b. OT Screen
	<input checked="" type="checkbox"/> c. ST Screen
	2. Restorative Program H
	<input type="checkbox"/> a. Restorative PT
	<input type="checkbox"/> b. Restorative OT
	<input type="checkbox"/> c. Restorative ST
	3. Order(s) Updated H
	<input type="checkbox"/> a. PT Order Update
	<input type="checkbox"/> b. OT Order Update
	<input type="checkbox"/> c. ST Order Update
	4. Other Recommendations H
	[Empty text area]

SECTION B. Therapy

Previous Section Cancel

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