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|  |  **Limitation Extension Evaluation** |
| NAME | BIRTHDATE | EVALUATION DATE |
| EVALUATOR’S NAME | CREDENTIAL NUMBER | TIME SPENT IN HOME |
| ADDRESS WHERE EVALUATION OCCURRED |
| INDIVIDUALS PRESENT AT EVALUATION |
| **Activities of Daily Living (ADL) / Instrumental Activities of Daily Living (IADL)** |
| Based on your observations:* Check “Yes” if the following ADLs / IADLs are within developmental milestones.
* Check “No” if they are not within developmental milestones.
 |
|  YES NO1. Ambulation [ ]  [ ]
2. Bed Mobility [ ]  [ ]
3. Transfers [ ]  [ ]
4. Toileting [ ]  [ ]
5. Eating [ ]  [ ]
6. Bathing [ ]  [ ]
 |  YES NO1. Dressing [ ]  [ ]
2. Personal Hygiene [ ]  [ ]
3. Medication Management [ ]  [ ]
4. Meal Preparation [ ]  [ ]
5. Housework [ ]  [ ]
 |
| For each ADL / IADL you have checked “No” above, please provide the following information. |
| NAME OF ADL / IADL NOT WITHIN DEVELOPMENTAL MILESTONES | FREQUENCY OF TASK PERFORMANCEtime per [ ]  day [ ]  week [ ]  month |
| Description of how task was accomplished. Describe the level of self-performance and the kind of support provided: |
| Could the task be accomplished more quickly or with less assistance? [ ]  Yes [ ]  NoIf yes, describe what would be needed to facilitate improved task accomplishment (e.g., assistive technology, durable medical equipment, training for support providers and/or clients that will allow task to be accomplished more quickly and/or with less assistance). |
| Estimated time to perform task based on recommendations:  |
| Demonstrate proper technique, if appropriate. Is this something that can be taught during the visit? Additional comments: |
| ISSUES AND CONCERNS IMPACTING THE DELIVERY OF CARE TO THE INDIVIDUAL |
| **Treatments / Programs** |
| TREATMENTS | CHECK IF RECEIVES | FREQUENCY (EXAMPLE: TWO TIMES PER DAY FOR 15 MINUTES EACH) | INDIVIDUAL PROVIDING TREATMENT(PARENT, SCHOOL, THERAPIST) |
| Sensory Integration Therapy | [ ]  |  |  |
| Occupational Therapy | [ ]  |  |  |
| Passive Range of Motion | [ ]  |  |  |
| Active Range of Motion | [ ]  |  |  |
| Splint / Brace Assistance | [ ]  |  |  |
| Weighted Vest / Blanket | [ ]  |  |  |
| Turning and Repositioning | [ ]  |  |  |
| Other:  | [ ]  |  |  |
| Other:  | [ ]  |  |  |
| TREATMENT DESCRIPTION / COMMENTS / RECOMMENDATIONS |
| You may make additional comments by attaching them to this document. |
| EVALUATOR’S SIGNATURE DATE |
| Return the completed Limitation Extension Evaluation form, DSHS 10-503, to the LE Committee **and** the authorizing prescriber.  **Email to**: LEcommittee@dshs.wa.gov **or****Fax to**: Attention:  LE Committee to  (360)407-0955 **or** **Mail to**: LE Committee P.O. Box 45310 Olympia, WA 98504-5310 |