Form A – Establishing Initial Occupational Priorities
Occupational Therapy (OT) Initial Evaluation – the COMPACT™ Checklist
(A Collaborative Occupational Measure of Performance and Change over Time)

Name: _____ Date: _____
Please check one: I am a Patient: _____ or a Family Member/Caregiver: _____

In OT, you are important to us! Please assist us in planning with you by completing the following checklist. Thank you!

1) Please check all tasks that you were doing prior to your hospitalization.
2) Next, check those activities where you currently experience difficulty.
3) Finally, check your 3-5 priority tasks to be used for OT treatment planning.

Activity Participation:	Step #1: Previously, I was doing:	Step #2: I am having difficulty with:	Step #3: My 3-5 priorities are:
Eating			
Dressing			
Bathing/Showering			
Toileting			
Personal grooming			
Walking/moving around			
Socializing			
Leisure/recreation activities			
Work activities			
Educational activities			
Sleeping & resting			
Care of family member(s)			
Using communication devices			
Sexual expression			
Care of pet(s)			
Driving or using public transport			
Financial management tasks			
Home cleaning & maintenance			
Meal preparation			
Laundry & ironing			
Shopping			
Church/spiritual or community activities			
Other:			

Of these activities, is there one that you'd like us to start with first?
Is there anything else that you'd like us to know?

Form A – Establishing Initial Occupational Priorities – Acute Medical Conditions
Occupational Therapy (OT) Initial Evaluation – the COMPACT™
(A Collaborative Occupational Measure of Performance and Change over Time)

Name: _____ Date: _____
Please check one: I am a Patient: _____ or a Family Member/Caregiver: _____

In OT, you are important to us! Please assist us in planning with you by completing the following checklist. Thank you!

1) Please check all tasks that you were doing prior to your hospitalization.
2) Next, check those activities where you currently experience difficulty.
3) Finally, check your 3-5 priority tasks to be used for your OT treatment planning.

Activity Participation:	**Step #1: Previously, I was doing:**	**Step #2: I am having difficulty with:**	**Step #3: My 3-5 priorities are:**
Eating			
Dressing			
Bathing/Showering			
Toileting			
Personal grooming			
Walking/moving around			
Sleeping & resting			
Communicating with others			
Using communication devices			
Other Daily Activities I would like to continue doing:			

Of these activities, is there one that you'd like us to start with first?

Is there anything else that you'd like us to know?

Form B – Collaborative Re-Assessment & Planning Form
The COMPACT™
(A Collaborative Occupational Measure of Performance and Change over Time)

Name: _____ **Date:** _____

Please assist us in re-assessing your priorities by completing the following checklist.

1) Please check all the activities that you (or your loved one) have been working on in OT.
2) Please rate your current ability to perform those desired activities on a **scale of 1 (less able) to 10 (very able).** (If you are a caregiver, please rate how well you would like your loved one to perform the tasks)
3) Finally, check your 3-5 priority tasks to be used for planning purposes.

Note: The last column will be completed by your occupational therapist in collaboration with you.

Activity Participation:	**How well I am doing in my OT activity (Rate from 1-10, less to more able):**	**My 3-5 OT Activity Priorities now are:**	**My new OT goals are:**
Eating			
Dressing			
Bathing/Showering			
Toileting			
Personal grooming			
Walking/moving around			
Socializing with others			
Leisure/recreation activities			
Work activities			
Educational activities			
Sleeping & resting			
Care of family			

member(s)			
Using communication devices			
Sexual expression			
Care of pet(s)			
Driving or using public transportation			
Financial management tasks			
Home cleaning & maintenance			
Meal preparation			
Laundry & ironing			
Shopping			
Going to church/spiritual or community activities			
Other activities:			

Form C – Collaborative Treatment Planning Tool (Patient with OT)
– The COMPACT™
(A Collaborative Occupational Measure of Performance and Change over Time)

Patient Name: _____ Rating Date:_____

Male: ____ Female: ____ Age: _____ Primary Diagnosis: _____

Impacting Diagnoses: _____

Location: Inpatient:___ Home: ___ Outpatient: ___ SNF: ___ Other: _____

Other Pertinent Information:

Form C – Collaborative Treatment Planning Tool (Patient with OT) – The COMPACT™ (A Collaborative Occupational Measure of Performance and Change over Time)

Activity Participation:	**Initial** Patient/ Caregiver Priorities (Check)	**Current** Patient/ Care-giver Priorities (Check)	**Patient Rating of Ability** (1-10 rating of less to more able in OT tasks)	**Therapist Rating of Patient Ability** (1-10 rating of less to more able: OT tasks)	**Collaborative Summary** (Top 3-5 Priorities)
Eating					
Dressing					
Bathing/Showering					
Toileting					
Personal grooming					
Walking/moving					
Socializing					
Leisure/recreation activities					
Work activities					
Educational activities					
Sleeping & resting					
Care of family member(s)					
Using communication devices					
Sexual expression					
Care of pet(s)					
Driving or using public transport.					
Financial management tasks					
Home cleaning & maintenance					
Meal preparation					
Laundry & ironing					
Shopping					
Church/spiritual or community activity					
Other:					

_ _

OT Collaborative Planning Outcomes Record (Provide a copy for the patient)

Patient Name: _____ Date: _____

Patient's Living Situation/Location (example: home with spouse):

Collaborative Goal and Priority Planning:

Patient will plan to do:

Family member or caregiver will plan to do:

Occupational Therapist will plan to do: