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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 NO   1. Ambulation 2. Bed Mobility 3. Transfers 4. Toileting 5. Eating 6. Bathing | | | | YES NO   1. 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 PERFORMANCE  time 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  No  If 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](mailto: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 | | | | | | |