# PATIENT EDUCATION PLAN
# REHABILITATION SERVICES

Patient Name: _____ DOB: _____ MR#: _____

**Medical Diagnosis:** _____ Date Initiated: _____

Functional Diagnosis: _____

**Assessment of Existing Knowledge/Skill Level:** (Past knowledge of condition, readiness and ability to learn, sensory or other limitations to learning.)

Able to Read Instructions? ❑ Yes ❑ No

Primary Language: _____

Translator Necessary? ❑ Yes ❑ No

❑ Other Limitations: _____

❑ Barriers to Learning: _____

Goals of Teaching: _____

Learning Objectives: _____

Method of Teaching: ❑ Information ❑ Discussion ❑ Demonstration

Learning Aids Used: ❑ Literature ❑ Audio-Visuals ❑ Models ❑ Supplies

**Teaching Plan:** (Information, participation by patient's family, estimated time of learning, etc.)

_____

_____

_____

**Evaluation:** Patient/Family Member:

| | | |
|---|---|---|
| ❑ Able to | ❑ Comprehend information | ❑ Achieved partial understanding |
| ❑ Not able to | ❑ Demonstrate the skill | ❑ Need to complete reinforcement |
| ❑ Skill only | ❑ Need for follow-up | ❑ Referred to: _____ |

**Follow-up/Reevaluation:** Date: _____

| | | |
|---|---|---|
| ❑ Able to | ❑ Comprehend information | ❑ Achieved partial understanding |
| ❑ Not able to | ❑ Demonstrate the skill | ❑ Need to complete reinforcement |
| ❑ Skill only | ❑ Need for follow-up | ❑ Referred to: _____ |

**Signatures:**

Patient: _____ Date: _____

Family/Significant Other: _____ Date: _____

Rehabilitation Therapist(s): _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____