PARTICIPANT READINESS EVALUATION SUMMARY
(RETURN TO CONGREGATE SERVICES)

Participant Name:	MR#:	Date:

*Any qualifying indicators on following list will be addressed in Notes section below.

PHYSICAL/COGNITIVE CONSIDERATION	**YES**	**NO**
Significant event/decline in ability/function in past six months	☐	☐
Referral required for additional evaluation by OT/PT/Diet/ST	☐	☐
Changes required to existing MDT care plans	☐	☐
Able to tolerate congregate services at minimum of 1x/week	☐	☐
COVID-19 Vaccine received	☐	☐
SOCIAL BARRIERS	**YES**	**NO**
Demonstrates satisfactory understanding of safety protocol for congregate	☐	☐
Demonstrates satisfactory understanding of modified program for congregate	☐	☐
Participant hesitant/unwilling to return to congregate services at current time	☐	☐
DOCUMENTATION	**YES**	**NO**
COVID-19 Vaccination Record	☐	☐
Primary Care Physician History and Physical (within the past six months)	☐	☐
Care Plan Indicated on IPC	☐	☐
Notes:		
Anticipated return date to congregate services		

MULTIDISCIPLINARY TEAM	
RN:	RD:
SW:	ST:
AC:	
OT:	
PT:	