

# Functional Dexterity Test (FDT) Assessment

## Patient Information

<b>Name:</b>
<b>Date of Birth:</b>
<b>Medical Record Number:</b>
<b>Date of Assessment:</b>

## Clinical History

## Indications for FDT

## Contraindications/Limitations

## **Nutritional Considerations**

## **Test Protocol**

### **1. Explanation to Patient**

### **2. Hand Dominance Determination**

### **3. Demonstration of Grasp Patterns**

### **4. Practice Rounds**

### **5. Timed Test Execution**

**6. Observations**

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**Results**

Right Hand:
Left Hand:
Notes:

**Interpretation**

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**Recommendations**

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**Follow-up**

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**Physician/Therapist Signature:** \_\_\_\_\_