Company Name

OCCUPATIONAL THERAPY TREATMENT NOTE

PLEASE PRINT

Patient Name:	MR #:	Therapist Name:

Medical / Rehab DX:

Contraindications / Risk Factors: ☐ Falls ☐ Other:

Universal Precautions Followed: ☐ Yes

Vital Signs (PRN): ☐ HR ________ per min resting; ☐ HR ________ per min with activity; ☐ BP _____/_____ resting; _____/_____ with activity
☐ Respiration _______ per min resting; ☐ Respiration _______ per min with activity

Homebound Status: *(check all that apply)* ☐ Pain with ambulation ☐ Requires assist of another with / without device to leave the home ☐ ↓Endurance
☐ ↓Strength ☐ ↓Balance ☐ Gait ataxia ☐ SOB with minimum exertion ☐ Other: ____________________

Subjective:

Objective: Home Exercise Program: Pt./cg. ☐ **Instruction** *(check all that apply)* ☐ Provided with Copy ☐ Updated ☐ Safety
☐ Observation / return demonstration ☐ Compliant / Independent ☐ Other: ____________________

Therapeutic Exercises: *(mark all that apply)* ☐ Resistive ☐ PROM ☐ AAROM ☐ Isometric ☐ Joint Stretching ☐ Other

ROM: Location	L/R	WB	Strength	Comments:

1 = Severe (Dep.) 2 = Moderate (Repetitive Verbal Cues / Physical Cues)
3 = Mild (verbal Cues / Supervision) 4 = WFL (Ind.)

1 = Max Assist. (75%-100%) 2 = Mod. Assist. (50-74%
3 = Min. Assist (25-49%) 4 = SBA/VC's (1-24%) 5 = Safe and Ind.

Impairment	Current	Impairment	Current	ADL'S:	Current	ADL'S:	Current
Sensation		Judgement/Safety		Grooming		Meal Prep.	
Attention Span		Problem Solving		Bathing		Ability to take Meds	
STM		Functional Comm.		Dressing UE		Light Laundry	
LTM		Level of Alertness		Dressing LE		Light Housekeeping	
Sequencing		Ability to follow Inst.		Toileting		Money Manage	
Perceptual				[illegible]g		Kitchen Manage	

Comments:

TRANSFERS: Pt./cg. ☐ Instruction ☐ Return demonstration
☐ Supine to Sit ________ assist. ☐ Sit to Stand ________ assist. ☐ Bed to Bedside commode ________ assist. ☐ Bed to Wheelchair ________ assist.
☐ Wheelchair to Commode ________ assist. ☐ Bath[illegible] commode ________ assist. ☐ Shower/Tub ________ assist. ☐ Car ________ assist.
Comments: ____________________

COORDINATION: ☐ N/A ____________________

AMBULATION: Pt./cg. ☐ Instruction ☐ Return demonstration
Pt. ambulates independently or with _________ (device) with ________ assist.
while performing ADL's / IADL's. Comments:____________________

ENDURANCE: ____ /5. ☐ No SO[illegible] Pt. exhibits SOB with
__________________ ADL activities [illegible]des w[illegible] ☐ [illegible]st or
__________________. ☐ Pt./cg [illegible] conservation
techniques. Comments: ____________________

NEUROLOGICAL: ☐ N/A ____________________

PAIN: ______ / 10 at ________________ (location) Pain managed by:
☐ Meds ☐ Exercise ☐ Modalities: (circle one) Massage / Heat /
Cryotherapy / Ultrasound (____________w/cm2 ☐ Pulse ☐ Cont)
☐ Other: ____________________
Time: _______ - _______ min Duration: ☐ PRN ☐ Other: ________________
☐ Pt./cg. instructed in pain management.
☐ Other: ____________________

VISION: ☐ N/A Pt./cg. ☐ Instru[illegible] low vision equipment ☐ Return demonstration of low vision equipment
Comments: ____________________

Assessment / Progress Toward Stated Goals: ____________________

Plan:

Communication: ☐ N/A ☐ Physician: ☐ SUP ☐ COTA ☐ PT ☐ PTA ☐ SN ☐ HHA Reason: ____________________

Change of POC: ☐ N/A ☐ Yex Frequency / Goals / Orders: Change: ____________________ Notified: ☐ MD ☐ Supervisor

Discharge: When: ☐ Goals are met ☐ Pt. is D/C to outpatient therapy ☐ Pt. returns to prior level of function. ☐ Other: ____________________
Patient/Caregiver comprehends discharge ☐ Yes ☐ No. If no, reason why: ____________________

Supervisory Visit: ☐ N/A ☐ Yes HHA Present: ☐ Yes ☐ No OTA Present: ☐ Yes ☐ No

☐ Follows Plan of Care ☐ Demonstrates competent skills ☐ Communicates effectively ☐ Notifies supervisor of patients needs/problems
Comments: ____________________

Modification to HHA Care Plan: ☐ Yes ☐ No ☐ Comments:

Patient Signature:	**Date:**	**Time In:**
Therapist Signature:	**Date:**	**Time Out:**

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