FIRST HEALTH SYSTEMS

OCCUPATIONAL THERAPY REVISIT NOTE

VITAL SIGNS: Temperature:____________ Pulse:____________ ☐ Regular ☐ Irregular Respirations:____________ ☐ Regular ☐ Irregular
Blood Pressure: Right_______/_______ Left_______/_______ ☐ Lying ☐ Standing ☐ Sitting ☐ O_2 saturation _____% (when ordered)
Pain: ☐ None ☐ Same ☐ Improved ☐ Worse Origin____________________ Location(s)____________________
Duration______________ Intensity 0-10______ Other______________ Relief measures____________________

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify)____________________

TYPE OF VISIT:
☐ Revisit
☐ Revisit and Supervisory Visit
☐ Other (specify) ____________
SOC DATE_____/_____/_____

TREATMENT DIAGNOSIS /PROBLEM AND EXPECTED OUTCOMES____________________

OCCUPATIONAL THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X".)

	Evaluation		Neuro-developmental training		Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
	Establish home exercise program		Sensory treatment		
	☐ Copy given to patient		Orthotics/Splinting		
	☐ Copy attached to chart		Adaptive equipment (fabrication and training)		Teach fall safety
	Patient/Family education				Pain management
	Independent living/ADL training		Teach alternative bathing skills (unable to use tub/shower safely)		Other:
	Muscle re-education				
	Perceptual motor training		Retraining of cognitive, feeding and perceptual skills		
	Fine motor coordination				

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES____________________

EVALUATION AND PATIENT/CAREGIVER RESPONSE____________________

CARE PLAN: ☐ Reviewed/Revised with patient involvement.
If revised, specify____________________
☐ Outcome/Instruction achieved (describe)____________________
☐ PRN order obtained for ____________________
APPROXIMATE NEXT VISIT DATE:_____/_____/_____
PLAN FOR NEXT VISIT____________________
DISCHARGE DISCUSSED WITH: ☐ Patient/Family
☐ Care Manager ☐ Physician ☐ Other (specify)____________
BILLABLE SUPPLIES RECORDED? ☐ N/A ☐ Yes (specify)
____
CARE COORDINATION: ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST
☐ MSW ☐ Aide ☐ Other (specify) ____________

SUPERVISORY VISIT (Complete if applicable)
☐ OT Assistant ☐ Aide / ☐ Present ☐ Not present
SUPERVISORY VISIT: ☐ Scheduled ☐ Unscheduled
OBSERVATION OF ____________________
TEACHING/TRAINING OF ____________________
PATIENT/FAMILY FEEDBACK ON SERVICES/CARE (specify)
____
NEXT SCHEDULED SUPERVISORY VISIT_____/_____/_____
If OT assistant/aide not present, specify date he/she was contacted regarding updated care plan:_____/_____/_____

SIGNATURES/DATES

X____________________ ____/____/____
Patient/Caregiver (if applicable) *Date*

Complete TIME OUT prior to signing below. Time In______ Time Out______
____________________ ____/____/____
Therapist (signature/title) *Date*

PATIENT NAME – Last, First, Middle Initial ID#

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