OCCUPATIONAL THERAPY REVISIT NOTE

DATE OF SERVICE ___/___/___

TIME IN _____ OUT _____

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 _____

EXPECTED TREATMENT OUTCOME(S) _____

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

	Evaluation (D1)		Neuro-developmental training (D7)		Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
	Establish rehab. program		Sensory treatment (D8)		
	Establish home exercise program		Orthotics/Splinting (D9)		Other:
	☐ Copy given to patient/client		Adaptive equipment (fabrication		
	☐ Copy attached to chart		and training) (D10)		
	Patient/Client/Family education		Teach alternative bathing skills		
	Independent living/ADL training (D2)		(unable to use tub/shower safely)		
	Muscle re-education (D3)		Retraining of cognitive, feeding		
	Perceptual motor training (D5)		and perceptual skills		
	Fine motor coordination (D6)		Body image training		

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES _____

EVALUATION AND PATIENT/CLIENT/CAREGIVER RESPONSE _____

CARE PLAN: ☐ Reviewed/Revised with patient/client involvement.
If revised, specify _____

☐ Outcome/Instruction achieved (describe) _____

☐ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ___/___/___
PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ☐ Patient/Client/Family
☐ Care Manager ☐ Physician ☐ Other (specify) _____
BILLABLE SUPPLIES RECORDED? ☐ N/A ☐ Yes (specify) _____

CARE COORDINATION: ☐ Physician ☐ PT ☐ OT ☐ ST ☐ SS
☐ SN ☐ Other (specify) _____

SUPERVISORY VISIT (Complete if applicable)

☐ OT Assistant ☐ Aide / ☐ Present ☐ Not present
SUPERVISORY VISIT: ☐ Scheduled ☐ Unscheduled
OBSERVATION OF _____

TEACHING/TRAINING OF _____

PATIENT/CLIENT/FAMILY FEEDBACK ON SERVICES/CARE (specify) _____

NEXT SCHEDULED SUPERVISORY VISIT ___/___/___
CARE PLAN UPDATED? ☐ No ☐ Yes (specify) _____

If OT assistant/aide **not present,** specify date he/she was contacted regarding updated care plan: ___/___/___

SIGNATURES/DATES

X _____ ___/___/___
Patient/Client/Caregiver (if applicable) *Date*

Complete **TIME OUT** (above) prior to signing below.
_____ ___/___/___
Therapist (signature/title) *Date*

PART 1 — Clinical Record **PART 2 — Therapist** **PART 3 — Care Coordination**

PATIENT/CLIENT NAME — Last, First, Middle Initial

ID#

