

PHYSICIAN PLAN OF CARE - CHANGE AND ADDITIONAL ORDERS

Patient/Client Name: _____ Date: _____
 Patient/Client Address: _____
 Physician's Name: _____
 Physician's Phone: _____ Fax: _____
 County: _____

Dear Doctor:

The orders shown below are being forwarded for your signature to authorize your verbal orders given on this date. Please sign and return this form within three (3) days for our patient's chart. *Thank you for the referral of your patient for services.*

Initial Evaluation Routine Visit
 Frequency/Duration _____ AS OF Date ____/____/____

OT Evaluation Date: ____/____/____ <input type="checkbox"/> To evaluate	Perceptual Motor Training <input type="checkbox"/> OT to provide perceptual motor training _____	Orthotics/Splinting <input type="checkbox"/> Provide training in donning/doffing of orthosis/splint <input type="checkbox"/> Monitor effectiveness of orthosis/splint and joint alignment <input type="checkbox"/> _____
ADL Training OT to provide training in: <input type="checkbox"/> Hygiene skills <input type="checkbox"/> Dressing skills <input type="checkbox"/> Feeding skills <input type="checkbox"/> Homemaking skills <input type="checkbox"/> Leisure skills	Fine Motor Coordination <input type="checkbox"/> OT to provide fine motor/dexterity activities <input type="checkbox"/> _____ <input type="checkbox"/> _____	Adaptive Equipment <input type="checkbox"/> OT to provide _____ _____
Muscle Re-Education OT to provide: <input type="checkbox"/> Facilitatory/Inhibitory exercises	Neurodevelopmental Treatment <input type="checkbox"/> OT to provide neurodevelopmental treatment _____ _____	Other OT to: <input type="checkbox"/> Establish home exercise program <input type="checkbox"/> _____ _____
	Sensory Treatment <input type="checkbox"/> OT to provide sensory integration training _____ _____	

GOALS: Rehab Potential: Good Fair

- Patient will demonstrate increased muscle strength of _____ (muscle(s) to _____ (grade) within _____ weeks.
- Patient will demonstrate increased ROM of _____ (joint(s) to _____ (ROM) within _____ weeks.
- Patient will demonstrate increased fine motor coordination of _____ to _____ within _____ weeks.
- Patient will demonstrate improvement of _____ transfers to _____ (level of assist) within _____ weeks.
- Patient/Caregiver will demonstrate appropriate use of _____ (assistive device/DME) within _____ days/weeks.
- Patient will demonstrate improvement in the following ADLs to the stated level of assistance within the stated weeks:
 _____ weeks
 _____ weeks
 _____ weeks
- Patient/Caregiver will be independent in home exercise program within _____ weeks.
- Patient/Caregiver will verbalize understanding of discharge plan within _____ days/weeks.
- Other: _____

Therapist's Signature: _____ Date: ____/____/____
 Physician's Signature: _____ Date: ____/____/____



Occupational Therapy Assessment/Note

Patient/Client Name: _____ Date: _____

Diagnosis: _____ Date of Onset: _____

<input type="checkbox"/> Initial Evaluation		<input type="checkbox"/> Follow up Visit		<input type="checkbox"/> Re-evaluation	
Trunk, Head, Shoulder Girdle:					
Upper Extremities:					
Hands:	Dominance:	<input type="checkbox"/> Right	<input type="checkbox"/> Left		
Endurance/Speed:					
Balance:	Sitting -	Standing - Static _____		Dynamic _____	
Mobility:					
Transfer Ability:					
DME / Adaptive Equipment Used:					
ADL: Feeding -					
Dressing -					
Grooming/Hygiene -					
Bathing -					
Homemaking -					
Psychological Status:					
Instruction:					
Patient Progress Toward Goals:					
Rehabilitation Program:					
Safety Risks Identifies:					
Independent Living/Daily ADLs		Perceptual Motor Training		Orthotics/Splinting	
Muscle Re-education		Fine Motor Coordination		Adaptive Equipment	
Reserved		Neurodevelopmental Treatment		Other	
Other		Sensory Treatment			

Time In: _____ Time Out: _____

Patient/Designee: I certify that the Matrix Home Care Employee listed on this time slip worked the times indicated and the work was performed in a satisfactory manner. I agree to the times regarding this time slip.

Patient/Client Signature: _____

OT Name (Print): _____ OT Signature: _____