matrix

The Primary Source for Home Care

Occupational Therapy Assessment/Note

Patient/Client Name: ______________________ Date: ____________

Diagnosis: ______________________ Date of Onset: ____________

☐ Initial Evaluation ☐ Follow up Visit ☐ Re-evaluation

Trunk, Head, Shoulder Girdle:

Upper Extremities:

Hands: Dominance: ☐ Right ☐ 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: ____________

8/03