Occupational Therapy Plan of Care

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: ___/___/___
- ❐ To evaluate

ADL Training
OT to provide training in:
- ❐ Hygiene skills
- ❐ Dressing skills
- ❐ Feeding skills
- ❐ Homemaking skills
- ❐ Leisure skills

Muscle Re-Education
OT to provide:
- ❐ Facilitatory/Inhibitory exercises

Perceptual Motor Training
- ❐ OT to provide perceptual motor training
- ❐ __________

Fine Motor Coordination
- ❐ OT to provide fine motor/dexterity activities
- ❐ __________
- ❐ __________

Neurodevelopmental Treatment
- ❐ OT to provide neurodevelopmental treatment

Sensory Treatment
- ❐ OT to provide sensory integration training

Orthotics/Splinting
- ❐ Provide training in donning/doffing of orthosis/splint
- ❐ Monitor effectiveness of orthosis/splint and joint alignment
- ❐ __________

Adaptive Equipment
- ❐ OT to provide

Other
OT to:
- ❐ Establish home exercise program
- ❐ __________

GOALS: Rehab Potential: ❐ Good ❐ Fair

1. Patient will demonstrate increased muscle strength of __________ (muscle(s) to ______ (grade) within ______ weeks.
2. Patient will demonstrate increased ROM of __________ (joint(s) to __________ (ROM) within ______ weeks.
3. Patient will demonstrate increased fine motor coordination of __________ to __________ within ______ weeks.
4. Patient will demonstrate improvement of __________ transfers to __________ (level of assist) within ______ weeks.
5. Patient/Caregiver will demonstrate appropriate use of __________ (assistive device/DME) within __________ days/weeks.
6. Patient will demonstrate improvement in the following ADLs to the stated level of assistance within the stated weeks:
   __________ __________ __________ weeks
   __________ __________ __________ weeks
   __________ __________ __________ weeks
7. Patient/Caregiver will be independent in home exercise program within __________ weeks.
8. Patient/Caregiver will verbalize understanding of discharge plan within __________ days/weeks.
9. Other: __________

Therapist's Signature: ______________________ Date: ___/___/___

Physician's Signature: ______________________ Date: ___/___/___