OT – Home Health Visit Note

PRIMA HOME HEALTH, LLC

Patient Name: _____ Visit Date: _____ Time In: _____ Time Out: _____

Agency Name: _____ OT Visit #: _____ Total Therapy Visit #: _____

Type of Visit: ☐ Initial ☐ OT Visit ☐ COTA Visit ☐ Supervisory (see addendum) ☐ Re-Assessment (see addendum) ☐ Discharge (see summary)

HOMEBOUND REASONS (Must Complete Criteria #1 and #2)

Criteria #1:	Criteria #2:
As a result of ☐ Illness ☐ Injury The patient requires aid of: ☐ Walker ☐ Cane ☐ Wheelchair ☐ Crutches ☐ Special Transportation ☐ Other ☐ Assistance of another person to leave place of residence	☐ There exists a normal inability to leave the home ☐ Leaving the home requires considerable and taxing effort due to: ☐ Shortness of breath ☐ Difficulty transferring ☐ Ambulation difficulties ☐ It is medically contraindicated to leave the residence ☐ Other: _____

Supportive Comments (specific to impairment limiting access outside residence): _____

SUBJECTIVE (Patient/Caregiver report of status change since last session): _____

VITAL SIGNS

Resting:	BP:	Pulse:	Respiratory Rate:	Pulse Ox:
With Activity:	BP:	Pulse:	Respiratory Rate:	Pulse Ox:
	Other:			

PAIN ASSESSMENT

Intensity(0-10, 10 being severe): _____

Location: _____

Effect on Function: _____

OCCUPATIONAL THERAPY SKILLED INTERVENTIONS PROVIDED THIS VISIT

Home Exercise Program:

☐ Developed ☐ Copy in Medical Records ☐ Copy given to patient/caregiver ☐ Reviewed

☐ Modifications/Progression (specify): _____

Equipment Provided:

☐ N/A ☐ Yes (specify): _____

Caregiver Training:

☐ Bed Mobility Skills ☐ Transfer Skills ☐ Effective use of assistive devices ☐ Precautions ☐ Safety and home program

☐ Home Modifications for Safety ☐ Splinting/Orthotic Training ☐ Other (specify): _____

Comments: _____

NARRATIVE (Patient's response to skilled interventions provided this visit)

Justification for Continued Services: _____

Treatment Plan: _____

Care Coordination With: ☐ Physician ☐ Nurse ☐ PT ☐ ST ☐ MSW ☐ HHA ☐ COTA ☐ Supervisor

Discussed: _____

Patient/Caregiver Signature: _____ **Date:** _____

Therapist Signature/Credentials: _____ **Date:** _____

Therapist Name (printed): _____

If COTA, Name of Supervising Therapist: _____