RHC
RECOVERY HOME CARE

OCCUPATIONAL THERAPY REVISIT NOTE

DATE OF SERVICE ___/___/___

TIME IN **OUT**

HOMEBOUND REASON:
- ☐ Needs assistance for all activities
- ☐ Residual weakness
- ☐ Confusion, unable to go out of home alone
- ☐ Requires assistance to ambulate
- ☐ 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)

TREATMENT DIAGNOSIS/PROBLEM _____

EXPECTED TREATMENT OUTCOME(S) _____

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

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

MEDICATION REGIMEN: Have there been any changes made to your medication regimen since your last skilled visit? ☐ No ☐ Yes
If yes, describe:

PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ☐ Patient/Client/Family ☐ Physician ☐ Care Manager
☐ Other (specify) _____

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

SUPERVISORY VISIT (Complete if applicable)

☐ COTA _____ ☐ HHA/CNA _____

OBSERVATION OF _____

TEACHING/TRAINING OF _____

FOLLOWING CARE PLAN? ☐ Yes ☐ No CARE PLAN UPDATED? ☐ Yes ☐ No

PATIENT SATISFIED WITH SERVICES? ☐ Yes ☐ No (If No, please explain) _____

SIGNATURES/DATES

Complete **TIME OUT** (above) prior to signing below.

X _____ ___/___/___ _____ ___/___/___

Patient/Client/Caregiver (if applicable) Date Therapist (signature/title) Date

PART 1 – Clinical Record PART 2 - Billing

PATIENT/CLIENT NAME -- Last, First, Middle Initial	ID#