ULTRA Health Care Inc.

OCCUPATIONAL THERAPY CARE PLAN

SOC DATE / /

DIAGNOSIS _____ ONSET / /

PROBLEM(S) _____

PATIENT/CLIENT DESIRED OUTCOMES	SHORT TERM OUTCOMES Time Frame	LONG TERM OUTCOMES Time Frame

PLAN OF CARE (Mark all applicable with an "X".)

☐ Evaluation (D1)	☐ Neuro-developmental training (D7)	☐ Body image training
☐ Establish rehab. program	☐ Sensory treatment (D8)	☐ Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
☐ Establish home exercise program	☐ Orthotics/Splinting (D9)	
☐ Copy given to patient/client	☐ Adaptive equipment (fabrication and training) (D10)	
☐ Copy attached to chart		☐ Other:
☐ Patient/Client/Family education	☐ Pain Management	
☐ Independent living/ADL training (D2)	☐ Teach alternative bathing skills (unable to use tub/shower safely)	
☐ Muscle re-education (D3)		
☐ Perceptual motor training (D5)	☐ Retraining of cognitive, feeding and perceptual skills	
☐ Fine motor coordination (D6)		

MODALITIES _____ REHAB POTENTIAL ☐ Good ☐ **Fair** ☐ **Poor**

FREQUENCY AND DURATION _____

EQUIPMENT RECOMMENDATIONS _____

SAFETY ISSUES/INSTRUCTION/EDUCATION _____

COMMENTS/ADDITIONAL INFORMATION _____

PATIENT/CLIENT/CAREGIVER RESPONSE TO PLAN OF CARE _____

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

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

APPROXIMATE NEXT VISIT DATE / /

PLAN FOR NEXT VISIT _____

PLAN DEVELOPED BY (signature/title/date) _____ / /

CARE PLAN REVIEW

DATE	REVIEWED/REVISED BY (signature/title)	COMMENTS

PART I - Clinical Record **PART 2 - Therapist**

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