ULTRA Health Care Inc.

OCCUPATIONAL THERAPY VISIT NOTE

DATE OF SERVICE ___/___/___

TIME IN _____ OUT _____

HOMEBOUND REASON: ❑ Needs assistance for all activities ☐ Residual weakness
❑ Requires assistance *to* ambulate ❑ Confusion, unable to go out of home alone
❑ 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)** _____
SOC DATE ___/___/___

TREATMENT DIAGNOSIS/PROBLEM _____

EXPECTED TREATMENT OUTCOME(S) _____

OCCUPATIONAL THERAPY INTERVENTIONS/INSTRUCTIONS (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
	Establish home exercise program		Orthotics/Splinting (D9)	X	to increase strength, coordination,
X	❑ Copy given to patient/client		Adaptive equipment (fabrication		sensation and proprioception
X	❑ Copy attached to chart	X	and training) (D10)		Other:
	Patient/Client/Family education		Pain Management		
	Independent living/ADL training (D2)		Teach alternative bathing skills		
	Muscle re-education (D3)	X	(unable to use tub/shower safely)		
	Perceptual motor training (D5)		Retraining of cognitive, feeding		
	Fine motor coordination (D6)	X	and perceptual skills		

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) _____

❑ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ___/___/___
PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ❑ Patient/Client/Family
❑ Care Manager ❑ Physician ❑ Other (specify) _____
BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify) _____

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

SUPERVISORY VISIT *(Complete if applicable)*

❑ OT Assistant ❑ Aide ❑ Present ❑ Not present
SUPERVISORY VISIT ❑ Scheduled ❑ Unscheduled
OBSERVATION OF _____

TEACHING/TRAINING OF _____

PATIENT/CLIENT/FAMILY FEEDBACK ON SERVICES/CARE
(specify) _____

NEXT SCHEDULED SUPERVISORY VISIT ___/___/___
CARE PLAN UPDATED? ❑ No ❑ Yes (specify) _____

If OT assistant/aide **not present,** specify date he/she was contacted regarding updated care plan: ___/___/___

SIGNATURES/DATES

X ___/___/___
Patient/Client/Caregiver (if applicable) Date

Complete TIME OUT (above) prior to signing below.
___/___/___
Therapist (signature/title) Date

PART 1 - Clinical Record **PART 2 - Therapist**

PATIENT/CLIENT NAME - Last, First, Middle Initial | ID4