### OCCUPATIONAL THERAPY CARE PLAN

**Diagnosis/ Reason for OT:**

**Frequency and Duration:**

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Fine motor coordination</th>
<th>Body image training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish/ upgrade home exercise program</td>
<td>Neuro-developmental training</td>
<td>Teach safe/effective use of adaptive/assist device (specify)</td>
</tr>
<tr>
<td>Copy given to patient</td>
<td>Sensory treatment</td>
<td>Muscle re-education</td>
</tr>
<tr>
<td>Copy attached to chart</td>
<td>Orthotics/Splinting</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient/Family education</th>
<th>Prosthetic training, Adaptive equipment, fabrication</th>
<th>Teach fall safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptual motor training</td>
<td>Pain Management</td>
<td>Therapeutic exercise to increase strength</td>
</tr>
<tr>
<td>Independent living/ADL training</td>
<td>Teach alternative bathing skills</td>
<td>Sensation and proprioception</td>
</tr>
<tr>
<td></td>
<td>Retraining of cognitive, feeding, and perceptual skills</td>
<td>Other:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Each modality specify frequency, duration, amount:

---

### SHORT TERM GOALS

- HEP will be established and initiated.
- Pain level will decreased from ___/10 to ___/10 within _____ weeks.
- Patient will be able to stand in kitchen to prepare meal for _____ min within _____ weeks.
- Patient will be able to reach _____ on _____ within _____ weeks.
- Patient will be able to lift _____ # pounds from _____ to _____ within _____ weeks.
- Patient will be able to wash _____ within _____ weeks.
- Patient will be able to integrate orthotic/prosthetic _____ to _____ within _____ weeks.
- Patient to be independent with safety issues in _____ weeks.
- Improve bathing skills, use to _____ within _____ weeks.
- Patient will retraining of cognitive, feeding, and perceptual skills within _____ weeks.
- Patient will be able to improve body image with _____ within _____ weeks.
- Independent with muscle re-education within _____ weeks.

### LONG TERM GOALS

- Patient will be able to finalize and demonstrate to follow up HEP.
- Pain level will decreased from ___/10 to ___/10 within _____ weeks.
- Patient will be able to stand in kitchen to prepare meal for _____ min within _____ weeks.
- Patient will be able to reach _____ on _____ within _____ weeks.
- Patient will be able to lift _____ # pounds from _____ to _____ within _____ weeks.
- Patient will be able to wash _____ within _____ weeks.
- Patient will be able to use orthotic/prosthetic _____ with/without assistance within _____ weeks.
- Increase strength _____ R L Hands within _____ weeks.
- Increase coordination _____ R L Hands within _____ weeks.
- Increase sensation _____ R L Hands within _____ weeks.
- Increase neuromuscular response by _____ within _____ weeks.
- Use of SPLITTING AND/OR EQUIPMENT independent within _____ weeks.
- Demonstrate hands motion to WNL within _____ weeks.

### ADDITIONAL SPECIFIC OCCUPATIONAL THERAPY GOALS

<table>
<thead>
<tr>
<th>Patient Expectation</th>
<th>SHORT TERM</th>
<th>Time Frame</th>
<th>LONG TERM</th>
<th>Time Frame</th>
</tr>
</thead>
</table>

### DISCHARGE PLANS DISCUSSED WITH:

- Patient/Family
- Care Manager
- Physician
- Other (specify)
- MSW
- Aide
- OTA
- Other (specify)

### APPROXIMATE NEXT VISIT DATE

**PLAN FOR NEXT VISIT**

**COMMENTS/ADDITIONAL INFORMATION**

---

**Patient Expectation SHORT TERM LONG TERM**

**Time Frame Time Frame**

---

**Equipment needed:**

**Patient/Caregiver aware and agreeable to POC:**

- Yes
- No
- (explain):

---

**GOALS: OCCUPATIONAL THERAPY**

**REHAB POTENTIAL:**

- Poor
- Fair
- Good
- Excellent

**DISCHARGE PLAN:**

- When goals met
- Other (specify)

Plan developed by:

<table>
<thead>
<tr>
<th>Therapist Name</th>
<th>Signature/title</th>
<th>Date</th>
</tr>
</thead>
</table>

Physician signature:

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

---

**Original - Physician Copy - Clinical Record (until signed original returned)**

**PATIENT NAME - Last, First, Middle Initial**

**ID#**
**OCCUPATIONAL THERAPY CARE PLAN**

**Diagnosis/ Reason for OT:**

**Frequency and Duration:**

### INTERVENTIONS

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Fine motor coordination</th>
<th>Body image training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish/ upgrade home exercise program</td>
<td>Neuro-developmental training</td>
<td>Teach safe/effective use of adaptive/assist device (specify)</td>
</tr>
<tr>
<td>Copy given to patient</td>
<td>Sensory treatment</td>
<td>Muscle re-education</td>
</tr>
<tr>
<td>Copy attached to chart</td>
<td>Orthotics/Splinting</td>
<td></td>
</tr>
</tbody>
</table>

**Patient/Family education**

- Prosthetic training, Adaptive equipment, fabrication
- Teach fall safety

**Perceptual motor training**

- Pain Management
- Teach alternative bathing skills

**Independent living/ADL training**

- Retraining of cognitive, feeding, and perceptual skills

**Note:** Each modality specify frequency, duration, amount:

### SHORT TERM GOALS

- **HEP will be established and initiated.**
- Pain level will decreased from ___/10 to ___/10 within ____ weeks.
- Patient will be able to stand in kitchen to prepare meal for ___ min within ____ weeks.
- Patient will be able to reach _________ on _________ within ________ weeks.
- Patient will be able to lift ____ # pounds from _________ to _________ within ________ weeks.
- Patient will be able to wash __________________________ within ________ weeks.
- Patient will be able to reach a Cup from _________ and took to _________ within ________ weeks.
- Patient will be able to integrate orthotic/prosthetic _________ to _________ within ________ weeks.
- Patient will be able to don/doff __________________________ independently within ________ weeks.

### LONG TERM GOALS

- Patient will be able to finalize and demonstrate to follow up HEP.
- Pain level will decreased from ___/10 to ___/10 within ____ weeks.
- Patient will be able to stand in kitchen to prepare meal for ___ min within ____ weeks.
- Patient will be able to reach _________ on _________ within ________ weeks.
- Patient will be able to lift ____ # pounds from _________ to _________ within ________ weeks.
- Patient will be able to wash __________________________ within ________ weeks.
- Patient will be able to reach a Cup from _________ and took to _________ within ________ weeks.
- Patient will be able to use orthotic/prosthetic _________ with/without assistance within ________ weeks.
- Patient will be able to don/doff __________________________ independently within ________ weeks.

### ADDITIONAL SPECIFIC OCCUPATIONAL THERAPY GOALS

<table>
<thead>
<tr>
<th>Patient Expectation</th>
<th>SHORT TERM</th>
<th>Time Frame</th>
<th>LONG TERM</th>
<th>Time Frame</th>
</tr>
</thead>
</table>

### DISCHARGE PLANS DISCUSSED WITH:

- Patient/Family
- Care Manager
- Physician
- Other (specify)

### CARE COORDINATION:

- Physician
- PT
- SN
- ST
- MSW
- Aide
- OTA
- Other (specify)

### SAFETY ISSUES/INSTRUCTION/EDUCATION:

### COMMENTS/ADDITIONAL INFORMATION:

**Equipment needed:**

**Patient/Caregiver aware and agreeable to POC:**

- Yes
- No (explain):

### GOALS: OCCUPATIONAL THERAPY

**REHAB POTENTIAL:**

- Poor
- Fair
- Good
- Excellent

**DISCHARGE PLAN:**

- When goals met
- Other (specify)

**Plan developed by:**

- Therapist Name
- Signature/title
- Date

**Physician signature:**

- Date

**APPROXIMATE NEXT VISIT DATE:**

**PLAN FOR NEXT VISIT**

**COMMENTS/ADDITIONAL INFORMATION:**

**Patient Name** - Last, First, Middle Initial

**ID#**

**Original - Physician**

**Copy - Clinical Record (until signed original returned)**
OCCUPATIONAL THERAPY

PAGE 2

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

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
- Medical restrictions
- Other (specify)

TYPE OF EVALUATION
- Initial
- Interim
- Final

SOC DATE

DATE OF SERVICE

TIME IN

OUT

ORDERS FOR EVALUATION ONLY?  Yes  No

If No, orders are

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEM

ONSET

MEDICAL PRECAUTIONS

ACTUAL LEVEL OF FUNCTION (ADL / IADL)

PRIOR LEVEL OF FUNCTION (ADL / IADL)

LIVING SITUATION/SUPPORT SYSTEM

ENVIRONMENTAL BARRIERS

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED

SENSORY/ PERCEPTUAL MOTOR SKILLS

LIGHT/FIRM TOUCH

SHARP/DULL

PROPRIOCEPTION

PROJECTION

VISUAL TRACKING

R/L DISCRIMINATION

MOTOR PLANNING PRAXIS

Do sensory/perceptual impairments affect safety?
- Yes
- No

COMMENTS:

COGNITIVE STATUS/COMPREHENSION

MEMORY

Short term

Long term

SAFEY AWARENESS

JUDGMENT

Visual Comprehension

Auditory Comprehension

SELF-CONTROL

PHYSICAL WELL-BEING

PSYCHOSOCIAL WELL-BEING

COMMENTS:

MOTOR COMPONENTS (Enter Appropriate Response)

FINE MOTOR COORDINATION (R)

GROSS MOTOR COORDINATION (R)

FINE MOTOR COORDINATION (L)

GROSS MOTOR COORDINATION (L)

ORTHOSES:

PRIOR TO INJURY:

- Right Handed
- Left Handed

OTHER DESCRIPTIONS

PROBLEM AREA

STRENGTH

ROM

ROM TYPE

TONICITY

OTHER DESCRIPTIONS

COMMENTS:

PATIENT/CLIENT NAME: Last, First, Middle Initial

ID #:

OCCUPATIONAL THERAPY EVALUATION
### FUNCTIONAL MOBILITY/BALANCE EVALUATION

<table>
<thead>
<tr>
<th>TASK</th>
<th>SCORE</th>
<th>COMMENTS</th>
<th>TASK</th>
<th>SCORE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BED MOBILITY</td>
<td></td>
<td></td>
<td>DYNAMIC SITTING BALANCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BED/WHEELCHAIR TRANSFER</td>
<td></td>
<td></td>
<td>STATIC SITTING BALANCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOILET TRANSFER</td>
<td></td>
<td></td>
<td>STATIC STANDING BALANCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TUB/SHOWER TRANSFER</td>
<td></td>
<td></td>
<td>DYNAMIC STANDING BALANCE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SELF CARE SKILLS

<table>
<thead>
<tr>
<th>AREA</th>
<th>DESCRIPTION</th>
<th>SCORE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEEDING</td>
<td>TOILETING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SWALLOWING</td>
<td>BATHING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FOOD TO MOUTH</td>
<td>UE DRESSING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORAL HYGIENE</td>
<td>LE DRESSING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GROOMING</td>
<td>MANIPULATION OF FASTENERS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INSTRUMENTAL ADL'S

<table>
<thead>
<tr>
<th>AREA</th>
<th>DESCRIPTION</th>
<th>SCORE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIGHT HOUSEKEEPING</td>
<td>USE OF TELEPHONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIGHT MEAL PREPARATION</td>
<td>MONEY MANAGEMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLOTHING CARE</td>
<td>MEDICATION MANAGEMENT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PATIENT GOALS:

### OBJECTIVE DATA TESTS AND SCALES

#### MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
<th>SCORE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Normal functional strength - against gravity - full resistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Good strength - against gravity with some resistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Fair strength - against gravity - no resistance - safety compromise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Poor strength - unable to move against gravity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Trace strength - slight muscle contraction - no motion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Muscle contraction.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### FUNCTIONAL RANGE OF MOTION (ROM) SCALE

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
<th>SCORE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>100% active functional motion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>75% active functional motion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>50% active functional motion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>25% active functional motion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Less than 25%.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### FUNCTIONAL INDEPENDENCE, SELF-CARE SKILLS AND INSTRUMENTAL ADL SCALE

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
<th>AREA</th>
<th>ACTION/ MOVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Physically able and does task independently.</td>
<td>Shoulder</td>
<td>Flex</td>
</tr>
<tr>
<td>4</td>
<td>Verbal cue (VC) only needed.</td>
<td>Abd.</td>
<td>170</td>
</tr>
<tr>
<td>3</td>
<td>Stand-by assist (SBA) - 100% patient/client effort.</td>
<td>Int. rot.</td>
<td>70</td>
</tr>
<tr>
<td>2</td>
<td>Minimum assist (Min A) - 75% patient/client effort.</td>
<td>Elbow</td>
<td>Flex</td>
</tr>
<tr>
<td>1</td>
<td>Maximum assist (Max A) - 25% - 50% patient/client effort.</td>
<td>Forearm</td>
<td>Sup.</td>
</tr>
<tr>
<td>0</td>
<td>Totally dependent - total</td>
<td>Wrist</td>
<td>Flex</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fingers</td>
<td>Flex all</td>
</tr>
</tbody>
</table>

#### AVERAGE RANGES OF JOINT MOTION (ROM)

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
<th>AREA</th>
<th>ACTION/ MOVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Independent</td>
<td>Cervical</td>
<td>Flex</td>
</tr>
<tr>
<td>4</td>
<td>Verbal cue (VC) only needed.</td>
<td>Spine</td>
<td>Rotation</td>
</tr>
<tr>
<td>3</td>
<td>Stand-by assist (SBA) - 100% patient/client effort.</td>
<td>Thumb</td>
<td>Abduction</td>
</tr>
</tbody>
</table>

### BALANCE SCALE (sitting-standing)

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
<th>AREA</th>
<th>ACTION/ MOVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Independent</td>
<td>Cervical</td>
<td>Flex</td>
</tr>
<tr>
<td>4</td>
<td>Verbal cue (VC) only needed.</td>
<td>Spine</td>
<td>Rotation</td>
</tr>
<tr>
<td>3</td>
<td>Stand-by assist (SBA) - 100% patient/client effort.</td>
<td>Thumb</td>
<td>Abduction</td>
</tr>
<tr>
<td>2</td>
<td>Minimum assist (Min A) - 75% patient/client effort.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Maximum assist (Max A) - 25% - 50% patient/client effort.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Totally dependent for support.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FOR RE-EVALUATION USE ONLY:

- IF A PREVIOUS PLAN OF CARE WAS ESTABLISHED, THEN IT WILL:
  - CHANGE
  - NOT CHANGE

### PATIENT'S NAME: ____________________________  MED. RECORD #: ____________________________

THERAPIST'S SIGNATURE/TITLE ____________________________  DATE __/__/________

PHYSICIAN'S SIGNATURE ____________________________  DATE __/__/________

* If no changes made to Initial Plan of care, MD signature no required.
ACTIVITIES PERMITTED:  ■ Complete Bedrest  ■ Bedrest/BRP  ■ Transfer Bed/ Chair  ■ Up as Tolerated  ■ Full Weightbearing  ■ Partial Weightbearing  ■ No Weightbearing  ■ Independent at Home  ■ No Restrictions  ■ Wheel Chair  ■ Walker  ■ Cane  ■ Crutches  ■ Hoyer Lift  ■ Stair Climbing  ■ Other

MENTALSTATUS:  ■ Oriented  ■ Forgetful  ■ Disoriented  ■ Agitated  ■ Comatose  ■ Depressed  ■ Lethargic  ■ Other

HOMEBOUND STATUS  ■ Bed bound  ■ Severe SOB  ■ Ambulates with Assist  ■ Uses W/C, Walker, Cane  ■ Up in Chair with max assist  ■ Severe Weakness  ■ Paralysis  ■ Unable to walk  ■ Balance/Gait - Unsteady  ■ Other

DUE TO:

Subjective Comments:

Specific Safety Issues Addressed:

TREATMENT RENDERED (If Pt/CG, instructed, see response below)

INSTRUCTED:  Pt  C.G

Assessment  ■  ■
Therapeutic Exercises/U.E.  ■  ■
Adaptive Equipment  ■  ■
Functional Transfer Training  ■  ■
Cognitive-Perceptual Re-Training  ■  ■
Homemaking/Accessibility  ■  ■
Energy Conservation  ■  ■
Joint Mobilization/Joint Protection Techniques  ■  ■
Heat/Cold Packs  ■  ■

PLAN OF CARE: PROBLEM - ACTION/PROGRESS TOWARD GOALS - PT'S/CG's RESPONSE TO TREATMENT/INSTRUCTION


Date/Describe:  

Next Scheduled Visit Date:  __________________________ Plan for Next Visit:  

Additions to Plan of Care  

Patient Name  

Therapist Name/Signature/Title  __________________________ Date:  __________________________
**OCCUPATIONAL THERAPY REVISIT NOTE**

**TYPE OF VISIT:**
- Revisit
- Revisit and Supervisory Visit

**HOMEBOUND REASON:**
- Requires assistance to ambulate
- Confusion, unable to go out of home alone
- Severe SOB, SOB upon exertion
- Other (specify): Medical restrictions

**RESIDUAL WEAKNESS:**
- Needs assistance for all activities
- Unable to safely leave home unassisted
- Dependent upon adaptive device(s)

**SOC DATE:**

**TREATMENT DIAGNOSIS/PROBLEM AND EXPECTED OUTCOMES:**

**TEACHING, TRAINING, RESPONSE TO INSTRUCTIONS:**
- Reviewed/Revised with patient involvement.

**CARE PLAN:**
- Reviewed/Revised with patient involvement.

**OBSERVATIONS, TREATMENT AND MEASURABLE OUTCOMES:**

**EVALUATION OF PATIENT/CAREGIVER RESPONSE TO TREATMENT:**

**TEACHING, TRAINING, RESPONSE TO INSTRUCTIONS:**
- To Patient
- To CG
- To Family
- Other:

**INSTRUCTION ABOUT:**
- Treatment, Equipment
- Other:

**TEACHING/TRAINING OF**

**PATIENT/FAMILY RESPONSE TO INSTRUCTIONS:**
- (specify)

**CARE PLAN UPDATED?**
- No
- Yes (specify, complete Modify Order)

**DISCHARGE PLANS DISCUSSED WITH:**
- Patient/Family
- Care Manager
- Physician
- Other (specify)

**BILLABLE SUPPLIES RECORDED?**
- N/A
- Yes (specify)

**CARE COORDINATION:**
- Physician
- PT
- SN
- ST
- MSW
- Aide
- Other (specify)

**SIGNATURES/DATES**

**DATE OF SERVICE:**

**TIME IN**

**TIME OUT**

**PART 1 - Clinical Record**

**PART 2 - Therapist**
OCCUPATIONAL THERAPY IN DEPTH ASSESSMENT

*This In Depth Assessment is to be completed in its entirety. No revisit note required!

OBJECTIVE DATA TESTS AND SCALES PRINTED ON Page 2

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 EVALUATION
☐ 13th Visit  ☐ 30 day Visit  ☐ Supervisory
☐ 19th Visit  ☐ Other indicate # ______

SOC DATE _______ / _______ / _______

HOMEBOUND REASON:
 Needs assistance for all activities
 Residual weakness

TYPE OF EVALUATION:
 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) _______

TREATMENT / DIAGNOSIS(ES) / PROBLEMS IDENTIFIED AT START OF CARE

__________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________
### Functional Mobility Balance Evaluation

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed/Wheelchair Transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet Transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tub/Shower Transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dynamic Sitting Balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static Sitting Balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static Standing Balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dynamic Standing Balance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Self Care Skills

<table>
<thead>
<tr>
<th>Skill</th>
<th>Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swallowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food to Mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ue Dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Hygiene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Le Dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manipulation of Fasteners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Light Housekeeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Light Meal Preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clothing Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Objective Data

### Tests and Scales

#### Manual Muscle Test (MMT) Muscle Strength

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Normal functional strength - against gravity - full resistance.</td>
</tr>
<tr>
<td>4</td>
<td>Good strength - against gravity with some resistance</td>
</tr>
<tr>
<td>3</td>
<td>Fair strength - against gravity - no resistance - safety compromise.</td>
</tr>
<tr>
<td>2</td>
<td>Poor strength - unable to move against gravity.</td>
</tr>
<tr>
<td>1</td>
<td>Trace strength - slight muscle contraction - no motion.</td>
</tr>
<tr>
<td>0</td>
<td>Zero - no active muscle contraction</td>
</tr>
</tbody>
</table>

#### Functional Independence, Self-Care Skills and Instrumental ADL Scale

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Physically able and does task independently</td>
</tr>
<tr>
<td>4</td>
<td>Verbal cue (VC) only needed.</td>
</tr>
<tr>
<td>3</td>
<td>Stand-by assist (SBA) - 100% patient/client effort.</td>
</tr>
<tr>
<td>2</td>
<td>Minimum assist (Min A) - 75% patient/client effort.</td>
</tr>
<tr>
<td>1</td>
<td>Maximum assist (Max A) - 25% - 50% patient/client effort.</td>
</tr>
<tr>
<td>0</td>
<td>Totally dependent - total care.</td>
</tr>
</tbody>
</table>

### Noted Deviations:

- Braces/prosthesis:

- Sensation (describe & include impact on function if appropriate):

- Safety Issues/Instruction (OT to document safety concerns and the training needed to address them):

### Discharge Plans/Rehab Potential

- **Rehab Potential: Fair** - Pt will be able to participate more effectively with ADL’s once _____ is controlled
- **Rehab Potential: Good** - Pt to be able to follow the plan of care/treatment regimen, and be able to self manage her/his condition.
- **Rehab Potential: Guarded** - minimal improvement in functional status expected and decline is possible.
- **Discharge Plan: TO D/C Pt when above goals met under care of caregiver and md follow-up**
- **Discharge Plan: Pt will be discharged when pt is able to function with assistance of caregiver within current limitations at home**
- **Discharge Plan: Pt will be discharged when Pt is able to function independently within current limitations at home**
- **Discharge Plan: To discharge to self in a safe environment with minimal assistance from CG, under the supervision of MD when all goals have been met.**
- **Other**

### Current Goals that pertain to current illness

- Progress Toward Goals/ Lack of Progress Toward Goals
  - Will increase functional activity by demonstrating ability to
Will verbalize understanding / demonstrate compliance with safety precautions within _____ ☐ weeks ☐ visits. Specify safety precautions: ____________________________________________

Pt. to dress UB/LB with ________ assist within _______ weeks ☐ visits.

Pt. to perform toileting with ________ assist within _______ weeks ☐ visits.

Pt. to perform toilet transfers with ________ assist within _______ weeks ☐ visits.

Pt. to perform shower/tub transfers with ________ assist within _______ weeks ☐ visits.

Pt. to bathe self with ________ assist within _______ weeks ☐ visits.

Pt. to groom self with ________ assist within _______ weeks ☐ visits.

Pt. to use adaptive equipment with ________ assist with _____ assist within _______ weeks ☐ visits.

Pt. to self-feed with ________ assist within _______ weeks ☐ visits.

Pt. will demonstrate increased ___ ROM of ______ to ______ degrees within _______ weeks ☐ visits.

Pt. to demonstrate increased strength of ________ (include specific joint, muscle, and indicate left, right or bilat.) to ______ within _______ weeks ☐ visits.

Additional Current Goals

Progress Toward Goals/ Lack of Progress Toward Goals

Other:

Other:

New goals:

Functional Reassessment Expectation of Progress Toward Goals

If lack of progress to goals, therapist and physician determination of need for continuation:

Supportable statement to continue therapy and why goals attainable:

Patient/ Caregiver response to Plan of Care:

Care coordination / Interdisciplinary communication (to address findings and plans to continue) with: ☐ Physician ☐ SN ☐ Case Manager ☐ COTA ☐ PT ☐ PTA ☐ ST ☐ MSW ☐ Other (specify)

Comments/ additional information:

Plan for next visit:

Changes to the POC:

Supervisory Visit: ☐ COTA ☐ HHA Staff Present ☐ Yes ☐ No Follows Precautions ☐ Yes ☐ No Follows POC ☐ Yes ☐ No

Performs Care: ☐ Yes ☐ No Patient Satisfied ☐ Yes ☐ No Coordination of Care ☐ Yes ☐ No Comments:

Patient/ Client Signature___________________________ Date_____/_____/_____ Time In _______ Time Out_______ Therapist Signature/ Title ____________________________ QI Review ☐ Yes Frequency Verified ☐ Yes Initials _______
CLIENT'S NAME:_________________________ MR#:_________________________

EMPLOYEE'S NAME:_________________________ DATE:_________________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the OT/OTA identify herself/himself and explain her/his duties at the first visit with you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did the OT/OTA explain the care provided according to the plan of care?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Did the OT/OTA provide care according to the scope of practice &amp; in response to meet your needs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Did you feel the OT/OTA was concerned with your health?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Were you able to express your feelings and opinions without reservation to the OT/OTA?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Were you able to participate in the care planning process and in your care?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Was the OT/OTA following dress code? Using ID badge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Was the OT/OTA prepared with appropriate supplies and equipment as needed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Was the OT/OTA on time for the visit or did he/she contact the client to change time?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Did the OT/OTA follow universal precaution and safety precaution?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Did the OT/OTA document care provided in the client's home chart?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Did the OT/OTA maintain confidentiality while providing care to you in your home.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Record Supervision**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the OT/OTA adequately document assessment, teaching and treatment performed in the home record? Are changes in treatments orders reported to the Agency?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did the OT/OTA notify the MD, DON or Case Manager when abnormal signs and symptoms were present and was this noted in the home record?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is the OT/OTA carrying out the established Plan of Care? If No, use the comment section to identify areas not addressed and the reason?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Does the OT/OTA report every 14 days or less the client's condition to the MD as per agency policy? (Physician status report)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Does the OT/OTA report to the Case Manager, DON any new or changed medication orders or modification to the plan or care regarding treatment orders and are theses changes documented in the home record and medication sheet?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:**

**Client information packet is present in the home?** Yes ___________ No ___________

**Client understands rights?** Yes ___________ No ___________

**CLIENT COMMENTS:**

**SUPERVISOR'S SIGNATURE:** ____________________________ DATE: ____________________________
# OT DISCHARGE/TRANSFER SUMMARY

**PATIENT NAME**

Admission Date: / /  
Discharge Date: / /  
Date of Last Billable Visit: / /  
Diagnosis (Primary)  

**SERVICES RENDERED:** Total # of actual visits  
RN  
HHA  
PT  
OT/ST  
MSW  
Other  

**REASON FOR DISCHARGE**  
☐ Partial - still receiving services of RN, PT, ST, OT, HHA  
☐ Complete  

**CONDITION ON DISCHARGE:**  
☐ Stable  
☐ Improved  
☐ Unstable  
☐ Deceased  

**DISPOSITION OF THE PATIENT:**  
☐ Able to care for self  
☐ Institutionalized  
☐ Family to assist  
☐ Homemaker to assist  
☐ Deceased  
☐ Other  

RN/PT/OT/ST contacted physician on / /  and discharged is approved.  

**SUMMARIES:**

<table>
<thead>
<tr>
<th>SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Verbalizes knowledge of medications, side effects, precautionary measures, diet, fluids, disease process, treatment program, s/s necessitating medical attention.</td>
</tr>
<tr>
<td>☐ Return to previous lifestyle with modification within disease limitations.</td>
</tr>
<tr>
<td>☐ Independence in self care within disease limitation</td>
</tr>
<tr>
<td>☐ Home free of hazards using proper safety</td>
</tr>
<tr>
<td>☐ Presenting symptoms absent and/or controlled by appropriate intervention</td>
</tr>
<tr>
<td>☐ Maximum potential attained within home setting.</td>
</tr>
</tbody>
</table>

**VITAL SIGNS**  

<table>
<thead>
<tr>
<th>On Discharge:</th>
<th>Vital Signs Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEMPERATURE TO</td>
<td>PULSE TO</td>
</tr>
<tr>
<td>RESPIRATION TO</td>
<td>BLOOD PRESSURE TO</td>
</tr>
<tr>
<td>/ /</td>
<td>/ /</td>
</tr>
</tbody>
</table>

**PATIENT/FAMILY INSTRUCTED IN:**  

| ☐ Post cataract care | ☐ Activity Restrictions |
| ☐ Injection Administration | ☐ Administration of Tube Feedings |
| ☐ Disease Process | ☐ Administration of Inhalation Rx |
| ☐ S/S of complications | ☐ IV Therapy |
| ☐ Action/Side effects of Medications | ☐ Indwelling Catheter Care/Precaut. |
| ☐ Foley Care | ☐ S/S Complications/infection |

Patient/Family response and adherence to teachings: ☐ Good ☐ Fair ☐ Poor ☐ Repetitive teaching required  
Goals Met: ☐ Yes ☐ No If No, explain  
Patient/Family Goals Met: ☐ Yes ☐ No If No, explain  

Employee’s Signature: 

Title:  
Date / /  

---

*This is a sample OT DISCHARGE/TRANSFER SUMMARY.*
## Additional Specific OT Goals Reached

<table>
<thead>
<tr>
<th>Patient Expectation</th>
<th>Short Term</th>
<th>Long Term</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Discharge Instructions Discussed With:

- Patient/Family
- Care Manager
- Physician
- Other (specify)

### Care Was Coordinated:

- Physician
- OT
- Aide
- OTA
- MSW
- Other (specify)

### Rehab Status:

- Poor
- Fair
- Good
- Excellent

- Discharged: Maximum functional potential reached
- Able to understand medication regimen and care related to disease

### Goals Documented by:

- Therapist Name/Signature/title

### Patient Name - Last, First, Middle Initial

- ID#