



Diagnosis/ Reason for OT: _____ ONSET: _____
 Frequency and Duration: _____ If applicable, portion of Plan of Care assigned to a PTA was discussed, explained to the OTA: Yes No N/A

INTERVENTIONS

Locator #21

Evaluation	Fine motor coordination	Body image training
Establish/ upgrade home exercise program <input type="checkbox"/> Copy given to patient <input type="checkbox"/> Copy attached to chart	Neuro-developmental training	Teach safe/effective use of adaptive/assist device (specify)
	Sensory treatment	Muscle re-education
	Orthotics/Splinting	Teach fall safety
Patient/Family education	Prosthetic training, Adaptive equipment, fabrication	Therapeutic exercise to _____ to increase strength coordination, sensation and proprioception
Perceptual motor training	Pain Management	Retraining of cognitive, feeding, and perceptual skills
Independent living/ADL training	Teach alternative bathing skills	Other: _____

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

SHORT TERM GOALS

LONG TERM GOALS

Locator #22

- 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 taked to _____ 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.

- 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 taked to _____ 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 Neuro response by _____ within ___ weeks.
- Use of SPLINTING AND/OR EQUIPMENT independent within ___ weeks.
- Demonstrate Hands motion to WNL within ___ weeks.

ADDITIONAL SPECIFIC OCCUPATIONAL THERAPY GOALS

Locator #22

Note: Each modality specify location, frequency, duration, and amount.

Patient Expectation	SHORT TERM	Time Frame	LONG TERM	Time Frame
<div style="position: absolute; top: 50%; left: 50%; transform: translate(-50%, -50%); opacity: 0.3; font-size: 48px; pointer-events: none;"> WWW.PSYSTEM.COM </div>				

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:

APPROXIMATE NEXT VISIT DATE: _____
 PLAN FOR NEXT VISIT _____

COMMENTS/ADDITIONAL INFORMATION:

Equipment needed: _____
 Patient/Caregiver aware and agreeable to POC: Yes No (explain): _____

GOALS: OCCUPATIONAL THERAPY

Locator #22

REHAB POTENTIAL: Poor Fair Good Excellent
 DISCHARGE PLAN: When goals met Other (specify) _____

Plan developed by: _____ Date _____
 Therapist Name Signature/title

Physician signature: _____ Date _____

Please sign and return promptly

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

PATIENT NAME - Last, First, Middle Initial ID#



Diagnosis/ Reason for OT: _____ ONSET: _____
 Frequency and Duration: _____

INTERVENTIONS

Locator #21

Evaluation	Fine motor coordination	Body image training
Establish/ upgrade home exercise program <input type="checkbox"/> Copy given to patient <input type="checkbox"/> Copy attached to chart	Neuro-developmental training	Teach safe/effective use of adaptive/assist device (specify)
	Sensory treatment	Muscle re-education
	Orthotics/Splinting	Teach fall safety
Patient/Family education	Prosthetic training, Adaptive equipment, fabrication	Therapeutic exercise to _____ to increase strength coordination, sensation and proprioception
Perceptual motor training	Pain Management	Other: _____
Independent living/ADL training	Teach alternative bathing skills	
	Retraining of cognitive, feeding, and perceptual skills	

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

SHORT TERM GOALS

LONG TERM GOALS

Locator #22

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> HEP will be established and initiated. <input type="checkbox"/> Pain level will decreased from ___/10 to ___/10 within ___ weeks. <input type="checkbox"/> Patient will be able to stand in kitchen to prepare meal for ___ min within ___ weeks. <input type="checkbox"/> Patient will be able to reach _____ on _____ within ___ weeks. <input type="checkbox"/> Patient will be able to lift ___ # pounds from _____ to _____ within ___ weeks. <input type="checkbox"/> Patient will be able to wash _____ within ___ weeks. <input type="checkbox"/> Patient will be able to reach a Cup from _____ and taked to _____ within ___ weeks. <input type="checkbox"/> Patient will be able to integrate orthotic/prosthetic _____ to _____ within ___ weeks. <input type="checkbox"/> Patient will be able to don/doff _____ with assistance of _____ within ___ weeks. | <ul style="list-style-type: none"> <input type="checkbox"/> Patient will be able to finalize and demonstrate to follow up HEP. <input type="checkbox"/> Pain level will decreased from ___/10 to ___/10 within ___ weeks. <input type="checkbox"/> Patient will be able to stand in kitchen to prepare meal for ___ min within ___ weeks. <input type="checkbox"/> Patient will be able to reach _____ on _____ within ___ weeks. <input type="checkbox"/> Patient will be able to lift ___ # pounds from _____ to _____ within ___ weeks. <input type="checkbox"/> Patient will be able to wash _____ within ___ weeks. <input type="checkbox"/> Patient will be able to reach a Cup from _____ and taked to _____ within ___ weeks. <input type="checkbox"/> Patient will be able to use orthotic/prosthetic _____ with/without assistance within ___ weeks. <input type="checkbox"/> Patient will be able to don/doff _____ independently within ___ weeks. |
|---|---|

ADDITIONAL SPECIFIC OCCUPATIONAL THERAPY GOALS

Locator #22

Note: Each modality specify location, frequency, duration, and amount.

Patient Expectation	SHORT TERM	Time Frame	LONG TERM	Time Frame

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:

APPROXIMATE NEXT VISIT DATE: _____
 PLAN FOR NEXT VISIT _____

 COMMENTS/ADDITIONAL INFORMATION:

Equipment needed: _____
 Patient/Caregiver aware and agreeable to POC: Yes No (explain): _____

GOALS: OCCUPATIONAL THERAPY

Locator #22

REHAB POTENTIAL: Poor Fair Good Excellent
 DISCHARGE PLAN: When goals met Other (specify) _____

Plan developed by: _____ Date _____
 Therapist Name Signature/title

Physician signature: _____ Date _____

Please sign and return promptly

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

PATIENT NAME - Last, First, Middle Initial ID#



OCCUPATIONAL THERAPY

EVALUATION RE-EVALUATION

DATE OF SERVICE _____ / _____ / _____

TIME IN _____ OUT _____

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

HOMEBOUND REASON: <input type="checkbox"/> Needs assistance for all activities <input type="checkbox"/> Residual weakness <input type="checkbox"/> Requires assistance to ambulate <input type="checkbox"/> Confusion, unable to go out of home alone <input type="checkbox"/> Unable to safely leave home unassisted <input type="checkbox"/> Severe SOB, SOB upon exertion <input type="checkbox"/> Dependent upon adaptive device(s) <input type="checkbox"/> Medical restrictions <input type="checkbox"/> Other (specify) _____	TYPE OF EVALUATION <input type="checkbox"/> Initial <input type="checkbox"/> Interim <input type="checkbox"/> Final SOC DATE _____ / _____ / _____ (if Initial Evaluation, complete Occupational Therapy Care Plan)
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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 _____

KEY: I - Intact, MIN - Minimally Impaired, MOD - Moderately Impaired, S- Severely Impaired, U- Untested/Unable to Test

SENSORY/ PERCEPTUAL MOTOR SKILLS							
Area	Sharp/Dull		Light/Firm Touch		Proprioception		VISUAL TRACKING: R/L DISCRIMINATION: MOTOR PLANNING PRAXIS: Do sensory/perceptual impairments affect safety? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, recommendations: COMMENTS:
	Right	Left	Right	Left	Right	Left	

COGNITIVE STATUS/COMPREHENSION						
Area	I	MIN	MOD	S	U	ABILITY TO EXPRESS NEEDS ATTENTION SPAN ORIENTED: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Reason for Therapy
MEMORY Short term						
Long term						
SAFETY AWARENESS						
JUDGMENT						
Visual Comprehension						
Auditory Comprehension						

MOTOR COMPONENTS (Enter Appropriate Response)															
Area	I	MIN	MOD	S	U	I	MIN	MOD	S	U	I	MIN	MOD	S	U
FINE MOTOR COORDINATION (R)															
FINE MOTOR COORDINATION (L)															
GROSS MOTOR COORDINATION (R)															
GROSS MOTOR COORDINATION (L)															

PRIOR TO INJURY: Right Handed Left Handed ORTHOSIS: Used Needed (Specify): _____

MUSCLE STRENGTH/ FUNCTIONAL ROM EVALUATION (Enter Appropriate Response)										
PROBLEM AREA	STRENGTH		ROM		ROM TYPE			TONICITY		OTHER DESCRIPTIONS
	Right	Left	Right	Left	P	AA	A	Hvøer	Hvoo	

COMMENTS: _____

PATIENT/CLIENT NAME: Last, First, Middle Initial	ID #:
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FUNCTIONAL MOBILITY/BALANCE EVALUATION

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
BED MOBILITY			DYNAMIC SITTING BALANCE		
BED/WHEELCHAIR TRANSFER			STATIC SITTING BALANCE		
TOILET TRANSFER			STATIC STANDING BALANCE		
TUB/SHOWER TRANSFER			DYNAMIC STANDING BALANCE		

SELF CARE SKILLS

FEEDING			TOILETING		
SWALLOWING			BATHING		
FOOD TO MOUTH			UE DRESSING		
ORAL HYGIENE			LE DRESSING		
GROOMING			MANIPULATION OF FASTENERS		

INSTRUMENTAL ADL'S

LIGHT HOUSEKEEPING			USE OF TELEPHONE		
LIGHT MEAL PREPARATION			MONEY MANAGEMENT		
CLOTHING CARE			MEDICATION MANAGEMENT		

PATIENT GOALS:

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH		FUNCTIONAL RANGE OF MOTION (ROM) SCALE	
GRADE	DESCRIPTION	GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance	5	100% active functional motion.
4	Good strength - against gravity with some resistance.	4	75% active functional motion.
3	Fair strength - against gravity - no resistance - safety compromise.	3	50% active functional motion.
2	Poor strength - unable to move against gravity.	2	25% active functional motion.
1	Trace strength - slight muscle contraction - no motion.	1	Less than 25%.
0	muscle contraction.		

FUNCTIONAL INDEPENDENCE, SELF-CARE SKILLS AND INSTRUMENTAL ADL SCALE **AVERAGE RANGES OF JOINT MOTION (ROM)**

GRADE	DESCRIPTION	AREA	ACTION/ MOVEMENT	
5	Physically able and does task independently.	Shoulder	Flex 158°	Extend 55°
4	Verbal cue (VC) only needed.		Abd. 170°	Add. 50°
3	Stand-by assist (SBA) - 100% patient/client effort.		Int. rot. 70°	Ext. rot. 90°
2	Minimum assist (Min A) - 75% patient/client effort.	Elbow	Flex 145°	Ext. 0°
1	Maximum assist (Max A) - 25% - 50% patient/client effort.	Forearm	Sup. 85°	Pron. 70°
0	Totally dependent - total	Wrist	Flex 73°	Ext. 70°
		Fingers	Flex all 90°	Ext. 0°
		Thumb	Abduction 50%	
		Cervical Spine	Flex 35°	Ext. 35°
			Rotation 45°	

BALANCE SCALE (sitting-standing)

GRADE	DESCRIPTION
5	Independent
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) - 100% patient/client effort.
2	Minimum assist (Min A) - 75% patient/client effort.
1	Maximum assist (Max A) - 25% patient/client effort.
0	Totally dependent for support.

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.



OCCUPATIONAL THERAPY WEEKLY SUMMARY REPORT

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 _____

MENTAL STATUS: Oriented Forgetful Disoriented Agitated Comatose Depressed Lethargic
 Other _____

HOMEBOUND STATUS DUE TO:	<input type="checkbox"/> Bed bound <input type="checkbox"/> Severe SOB	<input type="checkbox"/> Ambulates with Assist <input type="checkbox"/> Uses W/C, Walker, Cane
	<input type="checkbox"/> Up in Chair with max assist	<input type="checkbox"/> Severe Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Unable to walk
	<input type="checkbox"/> Balance/Gait - Unsteady	<input type="checkbox"/> Other _____

Subjective Comments: _____

Specific Safety Issues Addressed: _____

TREATMENT RENDERED (If Pt/CG. instructed. see response below)	INSTRUCTED:	Pt.	C.G
<input type="checkbox"/> Assessment _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Therapeutic Exercises/U.E. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adaptive Equipment _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Functional Transfer Training _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cognitive-Perceptual Re-Training _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Homemaking/Accessibility _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Energy Conservation _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Joint Mobilization/Joint Protection Techniques _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heat/Cold Packs _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Interdisciplinary Communication: R.N. P.T./P.T.A. O.T./OTA S.L.P. M.S.W. H.H.A. M.D.
 Date/Describe: _____

Next Scheduled Visit Date: _____ Plan for Next Visit: _____

Additions to Plan of Care _____

Patient Name _____

Therapist Name/Signature/Title _____ Date: _____



VITAL SIGNS: Temperature: _____ Pulse: _____ Regular Irregular Respirations: _____ Regular Irregular
 Blood Pressure: Right _____ / _____ Left _____ / _____ Lying Standing Sitting
 Pain: None Same Improved Worse Origin _____ Location(s) _____
 Duration _____ Intensity 0 1 2 3 4 5 6 7 8 9 10 _____ Other: _____ Relief measures _____

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 AND EXPECTED OUTCOMES: _____

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

Evaluation	Neuro-developmental training	Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
Establish home exercise program <input type="checkbox"/> Copy given to patient <input type="checkbox"/> Copy attached to chart	Sensory treatment	
Patient/Family education	Orthotics/Splinting	Teach fall safety
Independent living/ADL training	Adaptive equipment (fabrication and training)	Pain management
Muscle re-education	Teach alternative bathing skills (unable to use tub/shower safely)	Other: _____
Perceptual motor training	Retraining of cognitive, feeding and perceptual skills	
Fine motor coordination		

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES: _____

EVALUATION AND PATIENT/CAREGIVER RESPONSE: _____

<input type="checkbox"/> Modality used _____ <input type="checkbox"/> Location _____ <input type="checkbox"/> Frequency _____ <input type="checkbox"/> Duration _____ <input type="checkbox"/> Intensity _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Modality used _____ <input type="checkbox"/> Location _____ <input type="checkbox"/> Frequency _____ <input type="checkbox"/> Duration _____ <input type="checkbox"/> Intensity _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Modality used _____ <input type="checkbox"/> Location _____ <input type="checkbox"/> Frequency _____ <input type="checkbox"/> Duration _____ <input type="checkbox"/> Intensity _____ <input type="checkbox"/> Other _____
--	--	--

CARE PLAN: Reviewed/Revised with patient involvement.
 If revised, specify _____
 Outcome/Instruction achieved (describe) _____
 PRN order obtained
 APPROXIMATE NEXT VISIT DATE: ____/____/____
 PLAN FOR NEXT VISIT _____
 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) _____

SUPERVISORY VISIT (Complete if applicable)
 OT Assistant Aide Present Not present
 SUPERVISORY VISIT Scheduled Unscheduled
 OBSERVATION OF _____
 TEACHING/TRAINING OF _____
 PATIENT/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/Caregiver (if applicable) Date

Complete TIME OUT prior to signing below. Time In: ____/____/____ Time Out: ____/____/____

 Therapist (signature/title) Date

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

PATIENT NAME - Last, First, Middle Initial ID#

***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 ____/____/____

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

PERTINENT BACKGROUND INFORMATION

MEDICAL PRECAUTIONS


ADLs Independent Needed assistance Unable Equipment used &/or assistance require:

PRIOR LEVEL OF FUNCTION/WORK HISTORY

LIVING SITUATION/SUPPORT SYSTEM

ENVIRONMENTAL BARRIERS

PERTINENT MEDICAL/ SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED


 Impact on function? Yes No
 Describe _____
 PAIN (describe) _____
 Location(s) of Pain _____

KEY: I - Intact, MIN - Minimally Impaired, MOD - Moderately Impaired, S - Severely Impaired, U - Untested/Unable to Test

SENSORY/PERCEPTUAL MOTOR SKILLS

Area	Sharp/Dull		Light/Firm Touch		Proprioception		VISUAL TRACKING R/L DISCRIMINATION MOTOR PLANNING PRAXIS Do sensory/perceptual impairments affect safety? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, recommendations: COMMENTS:
	Right	Left	Right	Left	Right	Left	

COGNITIVE STATUS/COMPREHENSION

Area	I	S	Min	Mod	U	ABILITY TO EXPRESS NEEDS: ATTENTION SPAN: ORIENTED: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Reason for Therapy
MEMORY: Short term						PSYCHOSOCIAL WELL-BEING INITIATION OF ACTIVITY COPING SKILLS <input type="checkbox"/> Evaluate Further SELF-CONTROL
Long term						
SAFETY AWARENESS						
JUDGMENT						
Visual Comprehension						
Auditory Comprehension						

MOTOR COMPONENTS (Enter Appropriate Response)

	I	S	Min	Mod	U		I	S	Min	Mod	U
FINE MOTOR COORD (R)						GROSS MOTOR COORD (R)					
FINE MOTOR COORD (L)						GROSS MOTOR COORD (L)					

PRIOR TO INJURY: Right Handed Left Handed Splint/Orthosis: Used Needed (Specify):

MUSCLE STRENGTH/FUNCTIONAL ROM EVALUATION (Enter Appropriate Response)

PROBLEM AREA	Strength		ROM		ROM Type			Tonicity		Other Descriptions
	Right	Left	Right	Left	P	AA	A	Hyper	Hypo	

PATIENT/CLIENT NAME - Last, First, Middle Initial

ID#

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
FUNCTIONAL MOBILITY/BALANCE EVALUATION					
BED MOBILITY			DYNAMIC SITTING BALANCE		
BED/WHEELCHAIR TRANSFER			STATIC SITTING BALANCE		
TOILET TRANSFER			STATIC STANDING BALANCE		
TUB/SHOWER TRANSFER			DYNAMIC STANDING BALANCE		
SELF CARE SKILLS					
FEEDING			TOILETING		
SWALLOWING			BATHING		
FOOD TO MOUTH			UE DRESSING		
ORAL HYGIENE			LE DRESSING		
GROOMING			MANIPULATION OF FASTENERS		
INSTRUMENTAL ADL' s					
LIGHT HOUSEKEEPING			USE OF TELEPHONE		
LIGHT MEAL PREPARATION			MONEY MANAGEMENT		
CLOTHING CARE			MEDICATION MANAGEMENT		
OBJECTIVE DATA			TESTS AND SCALES		
MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH					
GRADE	DESCRIPTION				
5	Normal functional strength - against gravity - full resistance.				
4	Good strength - against gravity with some resistance				
3	Fair strength - against gravity - no resistance – safety compromise.				
2	Poor strength - unable to move against gravity.				
1	Trace strength - slight muscle contraction - no motion.				
0	Zero -no active muscle contraction				
FUNCTIONAL INDEPENDENCE, SELF-CARE SKILLS AND INSTRUMENTAL ADL SCALE					
GRADE	DESCRIPTION				
5	Physically able and does task independently				
4	Verbal cue (VC) only needed.				
3	Stand-by assist(SBA) - 100% patient/client effort.				
2	Minimum assist (Min A) - 75% patient/client effort.				
1	Maximum assist (Max A) - 25% - 50% patient/client effort.				
0	Totally dependent - total care.				
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					
<input type="checkbox"/>	Rehab Potential: Fair - Pt will be able to participate more effectively with ADL's once _____ is controlled	<input type="checkbox"/>	Rehab Potential: Good - Pt to be able to follow the plan of care/treatment regimen, and be able to self manage her/his condition	<input type="checkbox"/>	Rehab Potential: Guarded-minimal improvement in functional status expected and decline is possible.
<input type="checkbox"/>	Rehab Potential good for stated goals	<input type="checkbox"/>	Discharge Plan: TO D/C Pt when above goals met under care of caregiver and md follow-up	<input type="checkbox"/>	Discharge Plan: Pt will be discharged when pt is able to function with assistance of caregiver within current limitations at home
<input type="checkbox"/>	Discharge Plan: Pt will be discharged when Pt is able to function independently within current limitations at home	<input type="checkbox"/>	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.	<input type="checkbox"/>	Other
Current Goals that pertain to current illness			Progress Toward Goals/ Lack of Progress Toward Goals		
Will increase functional activity by demonstrating ability to					
PATIENT/CLIENT NAME - Last, First, Middle Initial				ID#	

_____ within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits.	
Will verbalize understanding / demonstrate compliance with safety precautions within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits. Specify safety precautions: _____	
Pt. to dress UB/LB with _____ assist within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits.	
Pt. to perform toileting with _____ assist within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt. to perform toilet transfers with _____ assist within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt. to perform shower/tub transfers with _____ assist within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt. to bathe self with _____ assist within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt. to groom self with _____ assist within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt. to use adaptive equipment with _____ assist with _____ assist within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt. to self-feed with _____ assist within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt. will demonstrate increased ___ ROM of _____ to _____ degrees within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt. to demonstrate increased strength of _____ (include specific joint, muscle, and indicate left, right or bilat.) to _____ within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Additional Current Goals	Progress Toward Goals/ Lack of Progress Toward Goals
Other:	
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: <input type="checkbox"/> Physician <input type="checkbox"/> SN <input type="checkbox"/> Case Manager <input type="checkbox"/> COTA <input type="checkbox"/> PT <input type="checkbox"/> PTA <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> Other (specify) _____	
Comments/additional information:	
Plan for next visit:	
Changes to the POC:	
Supervisory Visit: <input type="checkbox"/> COTA <input type="checkbox"/> HHA Staff Present <input type="checkbox"/> Yes <input type="checkbox"/> No Follows Precautions <input type="checkbox"/> Yes <input type="checkbox"/> No Follows POC <input type="checkbox"/> Yes <input type="checkbox"/> No	
Performs Care: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Satisfied <input type="checkbox"/> Yes <input type="checkbox"/> No Coordination of Care <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	
Patient/Client Signature _____	Therapist Signature/Title _____
Date _____/_____/_____ Time In _____ Time Out _____	QI Review <input type="checkbox"/> Yes Frequency Verified <input type="checkbox"/> Yes Initials _____

PATIENT/CLIENT NAME - Last, First, Middle Initial	ID#
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FIELD SUPERVISORY REPORT OT/OTA

CLIENT'S NAME: _____ MR#: _____

EMPLOYEE'S NAME: _____ DATE: _____

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

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) _____	DR. _____ Address: _____ _____ Tel. No. (_____) _____
SERVICES RENDERED: Total # of actual visits RN _____ HHA _____ PT _____ OT/ST _____ MSW _____ Other _____	REASON FOR DISCHARGE _____ <input type="checkbox"/> Partial - still receiving services of RN, PT, ST, OT, HHA <input type="checkbox"/> Complete

CONDITION ON DISCHARGE: ___ Stable ___ Improved ___ Unstable ___ Deceased	DISPOSITION OF THE PATIENT: ___ Able to care for self ___ Institutionalized ___ Family to assist ___ Homemaker to assist ___ Other: _____ ___ Deceased
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RN/PT/OT/ST contacted physician on ____/____/____ and discharged is approved.

SUMMARIES:

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

On Discharge: _____ _____ _____/____	VITAL SIGNS TEMPERATURE PULSE RESPIRATION BLOOD PRESSURE	Vital Signs Range _____ TO _____ _____ TO _____ _____ TO _____ ____/____ TO ____/____
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PATIENT/FAMILY INSTRUCTED IN:		
<input type="checkbox"/> Post cataract care <input type="checkbox"/> Injection Administration <input type="checkbox"/> Disease Process <input type="checkbox"/> S/S of complications <input type="checkbox"/> Action/Side effects of Medications	<input type="checkbox"/> Wound/Decubitus Care <input type="checkbox"/> Diabetic Management <input type="checkbox"/> Diet/Fluid Intake <input type="checkbox"/> Ostomy/Conduit Care <input type="checkbox"/> Safety Factors <input type="checkbox"/> Foley Care	<input type="checkbox"/> Activity Restrictions <input type="checkbox"/> Administration of Tube Feedings <input type="checkbox"/> Administration of Inhalation Rx <input type="checkbox"/> IV Therapy <input type="checkbox"/> Indwelling Catheter Care/Precaut. <input type="checkbox"/> 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 ____/____/____



OCCUPATIONAL THERAPY GOALS REACHED

POC (485) GOALS REACHED:

- DEMONSTRATED PROPER USE OF PROSTHESIS/BRACE/SPLINT DEMONSTRATED PROPER USE OF DME/HME.
- PATIENT AND/OR CG COMPREHEND AND DEMONSTRATED HOME EXERCISE PROGRAM
- PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN ADL'S, IADL'S.
- DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM
- IMPROVED THE USE OF ORTHOTIC, SPLINTING AND/OR EQUIPMENT, ASSISTIVE DEVICE: _____

- MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM
- PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN MUSCLE USE, MOTOR COORDINATION
- INCREASED STRENGTH OF RUE LUE RLE LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.
- PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN NEURO RESPONSE
- DISCHARGE PLANNED DISCUSSED WITH PATIENT / FAMILY

CARE PLAN SHORT/LONG TERM GOALS REACHED:

- Patient able to finalize and demonstrate to follow up HEP.
- Pain level decreased from ___/10 to ___/10
- Pt. able to stand in kitchen to prepare meal for ___ min
- Patient able to reach _____ on _____
- Patient able to lift ___ # pounds from ___ to ___
- Patient able to wash _____
- Patient able to reach a Cup from _____ and taked to _____
- Patient able to integrate orthotic/prosthetic _____ to _____
- Patient independent with safety issues in _____
- Improved bathing skills, use to _____
- Patient retraining of cognitive, feeding, and perceptual skills
- Patient able to improve body image with _____
- Independent with muscle re-education

- Increased strength R L Hands
- Increased coordination R L Hands
- Increased sensation R L Hands
- Increase Neuro response by _____
- Use of SPLINTING AND/OR EQUIPMENT independent
- Demonstrate Hands motion to WNL within

OTHER:

OTHER:

ADDITIONAL SPECIFIC OT GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

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

CARE WAS COORDINATED: Physician PT SN ST
 MSW Aide OTA Other (specify) _____

DISCHARGED: PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
 RETURNED TO INDEPENDENT LEVEL OF SELF CARE.
 ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____

REHAB STATUS: Poor Fair Good Excellent
 DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED
 ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE

ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED.

Goals documented by: _____ Date _____

 Therapist Name/Signature/title

PATIENT NAME - Last, First, Middle Initial

ID#

THERAPY DISCHARGE SUMMARY

PATIENT LAST NAME FIRST NAME PATIENT #

TYPE OF DISCHARGE: COMPLETE PARTIAL - STILL RECEIVING SERVICES OF: PT ST OT HHA SN

ADM DATE DISCH DATE DR

DIAGNOSIS (PRIMARY) ADDRESS

CITY, ST ZIP

VISITS RENDERED BY: RN HHA PT OT ST MSW

REASON FOR DISCHARGE: GOALS MET MOVED OUT OF AREA OTHER
 HOSPITALIZATION PATIENT EXPIRED
 SKILLED NURSING FACILITY CARE REFUSED
 TRANSFER TO ANOTHER AGENCY SKILLED CARE NO LONGER NEEDED

DISPOSITION SELF CARE NH ACLF FAMILY CARE OTHER

CONDITION IMPROVED STABLE UNSTABLE DECEASED REGRESSED

DEPENDENCY DEPENDENT INDEPENDENT REQUIRES SUPERVISION/ASSIST

EXERCISES PASSIVE ACTIVE ACTIVE ASSISTIVE RESISTIVE

PERFORMED WITH: R.U.E. R.L.E. L.U.E. L.L.E. TRUNK NECK

TRANSFER HOYER LIFT CRUTCHES WALKER

ACTIVITIES: W/C CANE QUAD CANE OTHER

GAIT TRAINING: N.W.B. P.W.B. F.W.B.

EVEN SURFACES STAIRS UNEVEN SURFACES

ASSISTANCE REQUIRED: MAXIMUM MINIMUM MODERATE GUARDING OTHER

DISTANCE AMBULATED: 20 ft. 40 ft. 60 ft. 80 ft. 100 ft. 120 ft.

INSTRUCTED ON HOME PROGRAM: PATIENT SIGNIFICANT OTHER FAMILY

NARRATIVE:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

Physical Therapy

- PATIENT HAS ACHIEVED ANTICIPATED GOALS
- PATIENT IS SAFELY INDEPENDENT WITHIN DISEASE LIMITATIONS
- ABSENCE OF PAIN
- FREE OF CONTRACTURES
- RANGE OF MOTION OF ALL JOINTS IS WITHIN NORMAL RANGE
- DEMONSTRATES RANGE OF MOTION EXERCISES
- DEMONSTRATES MUSCLE STRENGTHENING EXERCISES
- DEMONSTRATES TURNING AND POSITIONING SCHEDULE
- AMBULATES SAFELY WITH ASSISTIVE DEVICE
- AMBULATES SAFELY WITHOUT ASSISTIVE DEVICE

- DEMONSTRATES TRANSFER TECHNIQUE AND USE OF SPECIAL DEVICES
- DEMONSTRATES ABILITY TO DO SPECIAL TREATMENTS
- HEALED INCISION
- DEMONSTRATES STUMP WRAPPING AND HYGIENE
- DEMONSTRATES TECHNIQUE TO CARE FOR AND PROTECT FUNCTIONING EXTREMITY
- DESCRIBES PHANTOM LIMB SENSATION
- PATIENT DEMONSTRATES STABILIZATION OF AMBULATION

Speech Therapy

- PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
- PATIENT HAS ATTAINED MAXIMUM BENEFIT FROM THERAPEUTIC PROGRAM
- VERBAL AND SENTENCE FORMULATION AND COMPREHENSION IMPROVED TO MAXIMUM ATTAINMENT WITHIN DISEASE LIMITATIONS

Occupational Therapy

- PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
- DEMONSTRATES KNOWLEDGE OF OPERATION & CARE OF ADAPTIVE EQUIPMENT
- DEMONSTRATES ENERGY CONSERVATION/WORK SIMPLIFICATION TECHNIQUES
- DEMONSTRATIONS COMPENSATORY & SAFETY TECHNIQUES

PATIENT/S.O. RESPONSE AND ADHERENCE TO TEACHING: GOOD FAIR POOR

THERAPY GOALS MET: YES NO IF NO, EXPLAIN

PATIENT/S.O. GOALS MET: YES NO IF NO, EXPLAIN

COMMENTS:

PATIENTS/So. INSTRUCTED ON IMPORTANCE OF ADHERENCE OF EXERCISE PROGRAM, M.D. FOLLOW-UP AND NOTIFY M.D. IF COMPLICATIONS OCCUR. M.D. NOTIFIED OF DISCHARGE

THERAPIST SIGNATURE DATE