Sanz Health Services

OCCUPATIONAL THERAPY CARE PLAN

☐ INITIAL
☐ UPDATED

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 ☐ Copy given to patient ☐ Copy attached to chart	☐ Neuro-developmental training	☐ Teach safe/effective use of adaptive/assist device (specify)
	☐ Sensory treatment	
	☐ Orthotics/Splinting	☐ Muscle re-education
☐ Patient/Family education	☐ Prosthetic training, Adaptive equipment, fabrication	☐ Teach fall safety
☐ Perceptual motor training	☐ Pain Management	☐ Therapeutic exercise to _____ to increase strength coordination, sensation and proprioception
☐ Independent living/ADL training	☐ Teach alternative bathing skills	
☐	☐ Retraining of cognitive, feeding, and perceptual skills	☐ Other:

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

SHORT 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.

LONG TERM GOALS

Locator #22

- ❑ 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 whitin _____ 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

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: _____ (Therapist Name) _____ (Signature/title) Date _____

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 CARE PLAN

☐ INITIAL ☐ UPDATED

Diagnosis/ Reason for OT: _____ ONSET: _____

Frequency and Duration: _____

INTERVENTIONS

Locator #21

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

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

SHORT 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 will be able to don/doff _____ with assistance of _____ within _____weeks.

LONG TERM GOALS

Locator #22

- ❑ 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 whitin _____ weeks.
- ❑ 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: _____ (Therapist Name) _____ (Signature/title) Date _____

Physician signature: _____ Date _____

Please sign and return promptly

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

PATIENT NAME - Last, First, Middle Initial	ID#

Cruz & Sanz Health Services, Inc.

OCCUPATIONAL THERAPY

☐ EVALUATION ☐ RE-EVALUATION

DATE OF SERVICE ____/____/____

TIME IN _____ OUT _____

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
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) _____

TYPE OF EVALUATION
☐ Initial ☐ Interim ☐ Final
SOC DATE ____/____/____
(if Initial Evaluation, complete Occupational Therapy Care Plan)

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:
	Right	Left	Right	Left	Right	Left	R/L DISCRIMINATION:
							MOTOR PLANNING PRAXIS:
							Do sensory/perceptual impairments affect safety? ☐ Yes ☐ No
							If Yes, recommendations:
							COMMENTS:

COGNITIVE STATUS/COMPREHENSION

Area	I	MIN	MOD	S	U	ABILITY TO EXPRESS NEEDS
MEMORY Short term						ATTENTION SPAN
Long term						ORIENTED: ☐ Person ☐ Place ☐ Time ☐ Reason for Therapy
SAFETY AWARENESS						**PSYCHOSOCIAL WELL-BEING**
JUDGMENT						INITIATION OF ACTIVITY
Visual Comprehension						COPING SKILLS ☐ Evaluate Further
Auditory Comprehension						SELF-CONTROL

MOTOR COMPONENTS (Enter Appropriate Response)

Area	I	MIN	MOD	S	U		I	MIN	MOD	S	U
FINE MOTOR COORDINATION (R)						GROSS MOTOR COORDINATION (R)					
FINE MOTOR COORDINATION (L)						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	Hyper	Hypo	

COMMENTS: _____

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

Cruz & Sanz Health Services, Inc.

OCCUPATIONAL THERAPY (Cont'd.)

☐ EVALUATION ☐ RE-EVALUATION

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

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	muscle contraction.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	100% active functional motion.
4	75% active functional motion.
3	50% active functional motion.
2	25% active functional motion.
1	Less than 25%.

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

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.

AVERAGE RANGES OF JOINT MOTION (ROM)

AREA	ACTION/ MOVEMENT			
Shoulder	Flex	158°	Extend	55°
	Abd.	170°	Add.	50°
	Int. rot.	70°	Ext. rot.	90°
Elbow	Flex	145°	Ext.	0°
Forearm	Sup.	85°	Pron.	70°
Wrist	Flex	73°	Ext.	70°
Fingers	Flex all	90°	Ext.	0°
Thumb	Abduction	50%		
Cervical Spine	Flex	35°	Ext.	35°
	Rotation	45°		

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.*

Cruz & Sanz Health Services, Inc.

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 _____

MENTALSTATUS: ☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Comatose ☐ Depressed ☐ Lethargic
☐ Other _____

HOMEBOUND STATUS DUE TO: ☐ 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 _____

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

☐ 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: _____

DATE OF SERVICE: _____

OCCUPATIONAL THERAPY REVISIT NOTE

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS TIME IN _____ OUT _____

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: _____

SIGNS/SYMPTOMS THAT SHOULD BE PRESENT TO WARRANT ADMINISTRATION OF THE TREATMENT: _____

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		Sensory treatment		
X	☐ Copy given to patient ☐ Copy attached to chart		Orthotics/Splinting	X	
	Patient/Family education		Adaptive equipment (fabrication and training)		Teach fall safety
	Independent living/ADL training	X	Teach alternative bathing skills (unable to use tub/shower safely)		Pain management
	Muscle re-education				Other:
	Perceptual motor training		Retraining of cognitive, feeding and perceptual skills		
	Fine motor coordination	X			

OBSERVATIONS, TREATMENT AND MEASURABLE OUTCOMES: _____

EVALUATION OF PATIENT/CAREGIVER RESPONSE TO TREATMENT: _____

☐ Modality used _____	☐ Modality used _____	☐ Modality used _____
☐ Location _____	☐ Location _____	☐ Location _____
☐ Frequency _____	☐ Frequency _____	☐ Frequency _____
☐ Duration _____	☐ Duration _____	☐ Duration _____
☐ Intensity _____	☐ Intensity _____	☐ Intensity _____
☐ Other _____	☐ Other _____	☐ 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) _____

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)_____

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

SIGNATURES/DATES

X ____/____/____
Patient/Caregiver (if applicable, optional if weekly is used) 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#

Vital Care Home Health Services, Inc. | **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 _____/_____/_____

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

1 2 3 4 5 6 7 8 9 10

Location(s) of Pain _____

Impact on function? ❒ Yes ❒ No
Describe_____

PAIN (describe)_____

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
	Right	Left	Right	Left	Right	Left	R/L DISCRIMINATION
							MOTOR PLANNING PRAXIS
							Do sensory/perceptual impairments affect safety?
							❒ Yes ❒ No If Yes, recommendations:
							COMMENTS:

COGNITIVE STATUS/COMPREHENSION

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

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	

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

❒	**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.
❒	**Rehab Potential** good for stated goals	❒	**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	

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

_____ within _____ ❒ weeks ❒ visits.	
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 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:	
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_____ **Therapist Signature/Title** _____

Date_____/_____/_____ **Time In** _____**Time Out**_____ QI Review ❒ Yes Frequency Verified ❒ Yes Initials _____

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

Melanie Home Care, Corp.

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 theses 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:_____

Q.A. Nursing Services, Corp.

M.R.# _____

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 _____

☐ 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:

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	Vital Signs Range
_____	TEMPERATURE	_____ TO _____
_____	PULSE	_____ TO _____
_____	RESPIRATION	_____ TO _____
_____/_____	BLOOD PRESSURE	____/____ TO ____/____

PATIENT/FAMILY INSTRUCTED IN:

☐ Post cataract care	☐ Wound/Decubitus Care	☐ Activity Restrictions
☐ Injection Administration	☐ Diabetic Management	☐ Administration of Tube Feedings
☐ Disease Process	☐ Diet/Fluid Intake	☐ Administration of Inhalation Rx
☐ S/S of complications	☐ Ostomy/Conduit Care	☐ IV Therapy
☐ Action/Side effects of Medications	☐ Safety Factors	☐ 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 _____/_____/_____

OCCUPATIONAL THERAPY
DISCHARGE SUMMARY ADDENDUM

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 CORRECT BODY MECHANICS
- ❑ DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM
- ❑ IMPROVED THE USE OF ASSISTIVE DEVICE: _____
- ❑ MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM
- ❑ PATIENT AMBULATED WITH _____ (device) FOR _____ FT WITH _____ ASSIST
- ❑ INCREASED STRENGTH OF ❑ RUE ❑ LUE ❑ RLE ❑ LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.
- ❑ INCREASED RANGE OF MOTION (ROM) OF _____ JOINT TO _____ DEGREE FLEXION AND _____ DEGREE EXTENSION IN ____ WEEKS TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITY: _____.

CARE PLAN SHORT/LONG TERM GOALS REACHED:

GENERAL

- ❑ Gait increased tinetti gait score to _____ / 12
- ❑ Improved gait requiring ____ to _____ from _____ to _____

BED MOBILITY

- ❑ Pt. able to turn side (facing up) to lateral (left/right)
- ❑ Pt. able to butt scoot
- ❑ Pt. able to sit up with/without assistance
- ❑ Pt. able to self reposition
- ❑ IMPROVED BED MOBILITY (INDEPENDENT)

BALANCE

- ❑ Increased tinetti balance score to _____/16
- ❑ Pt. able to reach steady static/dynamic sitting/standing balance with/without assistance

TRANSFER

- ❑ Pt. able to transfer from _____ to _____ with/without assistance
- ❑ INDEPENDENT WITH TRANSFER SKILLS

STAIR/UNEVEN SURFACE

- ❑ Pt. able to climb stair/uneven surface with/without assistance ____ steps # _____

MUSCLE STRENGTH

- ❑ Pt. able to hold weigh _____ lb
- ❑ Pt. able to oppose flexion or extension force over _____

PAIN

- ❑ Pain decreased from _____/10 to _____ /10
- ❑ DEMONSTRATED EFFECTIVE PAIN MANAGEMENT
- ❑ PATIENT EXPERIENCED A DECREASE IN PAIN

ROM

- ❑ Pt. increased ROM of _____ by _____ degrees flexion/extension

SAFETY

- ❑ Pt. able to use _____ independently to _____ feet
- ❑ Pt. able to self propel wheel chair _____ feet
- ❑ Pt able to finalize and demonstrated to follow up HEP.

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#