etairos Your Partner at Home HEALTH

Date: _____

OCCUPATIONAL THERAPY VISIT NOTE

Patient Name: _____	**Employee Name:** _____
Patient Signature: _____	**Employee Signature:** _____
	Time In: _____ **Time Out:** _____

Diagnosis: _____ Precautions: _____

Patient/Family Comments: _____

☐ Functional/Strengthening/Re-ed Exercise to _____ using _____

☐ PROM exercise to _____

☐ AROM exercise to _____

☐ AAROM exercise to _____

☐ Coordination Training

☐ Orthotics/Splinting to _____

☐ Oral Motor Techniques

☐ W/C Measurement/Fittings

☐ Grooming/Personal Hygiene Training

☐ Dressing Training

☐ Bathing Training

☐ Toileting Training

☐ Feeding Training

☐ Homemaking Training

☐ Meal Preparation Training

☐ Transfer Training to _____

☐ Other

☐ Neuro Developmental Training

☐ Perceptual Training

☐ Dysphagic Treatment

☐ Behavior Modification Techniques

☐ Pain Management

☐ Location of Pain _____

☐ Frequency of Pain _____

☐ Level of Pain 0 1 2 3 4 5

☐ Intractable Pain ☐ Yes ☐ No

☐ Pain Meds Used ☐ Yes ☐ No

☐ Meds Effective ☐ Yes ☐ No

☐ Other Pain Management Methods Used

_____

_____

☐ Effective ☐ Yes ☐ No

☐ Other _____

☐ Educational Materials on Pain Management Given ☐ Yes ☐ No If "yes" ☐ This Visit or ☐ Prior Visits

Comments: _____

_____

_____

INSTRUCTIONS / SUPERVISION: ☐ Patient ☐ HHA ☐ Family/Caregiver

☐ Home Exercise Program	☐ Disease Process	☐ Perceptual Compensatory Techniques
☐ Energy Conservation Techniques	☐ Safety Measures	☐ Use of Assistive Devices/Orthotics
☐ Functional Application of Body Mechanics in ADLS	☐ Instruct/Reinforce Orthopedic Precautions	☐ Emergency Management
☐ Positioning	☐ W/C Operations	☐ Discharge Teaching
☐ Transfers	☐ ADL Techniques	

☐ Other: _____

Comments: _____

_____

Assessment/Progress Towards Goals: _____

_____

_____

Communication With Other Disciplines: _____

Plan for Next Treatment: _____

_____

Narrative: _____

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Therapist Signature: _____ Date: _____