

Just Kier

# OCCUPATIONAL THERAPY REVISIT NOTE

DATE OF SERVICE: \_\_\_/\_\_\_/\_\_\_  
TIME IN: \_\_\_ TIME OUT: \_\_\_

**VITAL SIGNS:** Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ Regular / Irregular Resp.: \_\_\_\_\_ B/P: \_\_\_\_\_  
Using O<sub>2</sub> at \_\_\_\_\_ LPM via: \_\_\_\_\_  
**PAIN:** Rating scale: 0 1 2 3 4 5 6 7 8 9 10  
No pain Mod pain Worst pain  
Pain quality: \_\_\_\_\_ Pain location: \_\_\_\_\_  
(ache, sharp, etc.) (subjective reporting)  
Frequency: \_\_\_\_\_

**TYPE OF VISIT:**  
 Revisit and Supervisory Visit  
**SOC DATE** \_\_\_/\_\_\_/\_\_\_  
 G0152 OT  G0158 OTA

**HOMEBOUND REASON:**  
 Needs assistance for all activities  
 Residual weakness  
 Requires assistance to ambulate  
 Unable to safely leave home unassisted  
 Dependent upon adaptive device(s)  
 Confusion, unable to go out of home alone  
 Severe SOB, SOB upon exertion  
 Medical restrictions  
 Other (specify): \_\_\_\_\_

**Treatment Diagnosis/Problem Area(s):**  
 Coordination deficits (Fine/Gross)  
 Upper body weakness/limited ROM  
 Visual disturbances/deficits/limitations  
 Difficulty with dressing/bathing/grooming/hygiene/toileting  
 Difficulty with homemaking skills/money management/laundry/meal prep  
 Cognition (memory, orient, etc.)  
 Impaired attention/concentration/problem solving, sequencing  
 Other: \_\_\_\_\_

### OCCUPATIONAL THERAPY INTERVENTIONS

Establish HEP:  
 Given to Pt  In Chart  
 Patient Education  
 Family/Caregiver Education  
 Activities of Daily Living  
 Instrumental Activities of Daily Living  
 Therapeutic Exercise  
 Neuro-Muscular Re-education  
 Therapeutic Activity  
 Cognition  
 Adaptive Equipment Training  
 Visual/Perceptual Skills  
 Sensory Integration/Stimulation  
 Splinting (fabrication/modification)  
 Other: \_\_\_\_\_

### GOALS/OUTCOMES: Patient/Caregiver/Therapist identified functional based goals (areas identified in evaluation)

Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards Independence:
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Adaptive Equipment Needs Identified and/or Trained on: \_\_\_\_\_ Patient/Caregiver/Family Response: \_\_\_\_\_

Demonstrates Rehab Potential as:  Poor  Fair  Good  Excellent  
Patient demonstrates potential for continued gains towards a greater level of functional independence and will benefit from continued Occupational Therapy Services to address deficit areas impacting this. Please see Occupational Therapy Evaluation and Plan of Care for further detailed information regarding current functional level and areas of focus.

**CARE PLAN:**  Reviewed/Revised with Patient/Caregiver/Family  
Revised:  Yes  No (specify) \_\_\_\_\_

### SUPERVISORY VISIT (Complete if applicable)

OT Assistant  Aide /  Present  Not present  
Supervisory Visit:  Scheduled  Unscheduled  
Observation of: \_\_\_\_\_  
Teaching/Training of: \_\_\_\_\_  
Next Scheduled Supervisory Visit: \_\_\_\_\_  
Care plan reviewed/revised with assistant/aide during this visit:  
 Yes  No If yes (specify) \_\_\_\_\_  
If OT assistant/aide not present, specify date he/she was contacted regarding updated care plan: \_\_\_/\_\_\_/\_\_\_

APPROXIMATE NEXT VISIT DATE: \_\_\_/\_\_\_/\_\_\_  
PLAN FOR NEXT VISIT: \_\_\_\_\_

DISCHARGE PLAN DISCUSSED WITH:  Patient/Family  
 Care Manager  Physician  Other: \_\_\_\_\_

BILLABLE SUPPLIES USED?  N/A  Yes (specify) \_\_\_\_\_

CARE COORDINATION DISCUSSED WITH:  Physician  Nursing  
 PT  OT  ST  MSW  Aide  Other: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### SIGNATURES/DATES

Patient/Caregiver (if applicable) \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_  
Complete TIME OUT (above) prior to signing below.  
Therapist (signature/initial) \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

PART 1 - Clinical Record      PART 2 - Therapist

PATIENT NAME - Last, First, Middle Initial \_\_\_\_\_ ID# \_\_\_\_\_