OCCUPATIONAL THERAPY REVISIT NOTE

DATE OF SERVICE:____/____/____
TIME IN_____ TIME OUT_____

VITAL SIGNS: Temp:_____ Pulse:_____ Regular / Irregular Resp.:_____ B/P:_____
Using O_2 at _____ LPM via:_____
PAIN: Rating scale: 0 1 2 3 4 5 6 7 8 9 10 (0 No pain, 5 Mod pain, 10 Worst pain) Current pain level:_____ (subjective reporting)
Pain quality:_____ (ache, sharp, etc.) Pain location:_____ 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)_____

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_____

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:____/____/____

Comments:_____

SIGNATURES/DATES

X_____ ____/____/____
Patient/Caregiver (if applicable) *Date*

Complete TIME OUT (above) prior to signing below.
_____ ____/____/____
Therapist (signature/title) *Date*

PART 1 – Clinical Record **PART 2 – Therapist**

PATIENT NAME – Last, First, Middle Initial	ID#