ocean One

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, 9–10 = 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:

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# ________