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 (No pain) 1 2 3 4 5 6 7 8 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:
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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#