OCCUPATIONAL THERAPY CARE PLAN

SOC DATE_____/_____/_____

DIAGNOSIS/REASON FOR OT: _____ **ONSET**_____/_____/_____

FREQUENCY AND DURATION: _____

❑ Physician orders obtained.

❑ Physician orders needed. **Follow organization procedure for obtaining verbal orders and completing the 485/POC or submitting supplemental orders for physician signature.**

OCCUPATIONAL THERAPY INTERVENTIONS

Locator #21

❑ Evaluation	❑ Neuro-developmental training	❑ Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
❑ Establish home exercise program ❑ Copy given to patient ❑ Copy attached to chart	❑ Sensory treatment	❑ Teach fall safety
❑ Patient/Family education	❑ Orthotics/Splinting	❑ Pulse oximetry PRN
❑ Independent living/ADL training	❑ Adaptive equipment (fabrication and training)	❑ Other:
❑ Muscle re-education	❑ Teach alternative bathing skills (unable to use tub/shower safely)	
❑ Perceptual motor training	❑ Retraining of cognitive, feeding and perceptual skills	
❑ Fine motor coordination		

OUTCOMES

Locator #22

Note: Each modality specify location, frequency, duration and amount.

PATIENT DESIRED	SHORT TERM Time Frame	LONG TERM Time Frame

Equipment needed: _____

Patient/Caregiver aware and agreeable to POC: ❑ Yes ❑ No (explain) _____

GOALS: OCCUPATIONAL THERAPY

Locator #22

❑ Demonstrates ability to follow home exercise program by _____ (date).

❑ Demonstrates outcomes met by _____ (date).

❑ Other (specify) _____ by _____ (date).

REHAB POTENTIAL: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

DISCHARGE PLAN: ❑ When goals met ❑ Other (specify) _____

Plan developed by: _____ Date_____

Professional signature/title

Occupational Therapy Care Plan and Physician Orders

NOTE: To be used ONLY For Supplemental Orders to Plan of Care/485 for Therapy Services.
When patient under hospice POC, the IDT determines changes to the POC with the medical director and/or attending physician.

Recommended Plan, Outcomes, Frequency & Duration as above.

Verbal orders from physician by: _____ Date_____

Professional signature/title

Physician signature: _____ Date_____

Please sign and return promptly

Original to Physician **Copy to Clinical Record (until signed original returned)**

PATIENT NAME – Last, First, Middle Initial	ID#