OCCUPATIONAL THERAPY REVISIT NOTE

DATE OF SERVICE ___/___/___

TIME IN _____ **OUT** _____

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

TYPE OF VISIT:
❑ Revisit
❑ Revisit and Supervisory Visit
❑ Other (specify) _____
SOC DATE ___/___/___

TREATMENT DIAGNOSIS/PROBLEM _____

EXPECTED TREATMENT OUTCOME(S) _____

OCCUPATIONAL THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X".)

☐ Evaluation (D1)	☐ Neuro-developmental training (D7)	☐ Body image training
☐ Establish rehab. program	☐ Sensory treatment (D8)	☐ Therapeutic exercise to right/left hand
☐ Establish home exercise program	☐ Orthotics/Splinting (D9)	■ to increase strength, coordination,
■ ❑ Copy given to patient	☐ Adaptive equipment (fabrication	■ sensation and proprioception
■ ❑ Copy attached to chart	■ and training) (D10)	☐ Other:
☐ Patient/Family education	☐ Pain Management	☐
☐ Independent living/ADL training (D2)	☐ Teach alternative bathing skills	☐
☐ Muscle re-education (D3)	■ (unable to use tub/shower safely)	☐
☐ Perceptual motor training (D5)	☐ Retraining of cognitive, feeding	☐
☐ Fine motor coordination (D6)	■ and perceptual skills	☐

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES _____

EVALUATION AND PATIENT/CAREGIVER RESPONSE _____

CARE PLAN: ❑ Reviewed/Revised with patient involvement.
If revised, specify _____

❑ Outcome/Instruction achieved (describe) _____

❑ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ___/___/___
PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ❑ Patient/Family
❑ Care Manager ❑ Physician ❑ Other (specify) _____
BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify) _____

CARE COORDINATION: ❑ Physician ❑ PT ❑ OT ❑ ST ❑ SS
❑ SN ❑ Other (specify) _____

SUPERVISORY VISIT (Complete if applicable)

❑ OT Assistant ❑ Aide / ❑ Present ❑ Not present
SUPERVISORY VISIT: ❑ Scheduled ❑ Unscheduled
OBSERVATION OF _____

TEACHING/TRAINING OF _____

PATIENT/FAMILY FEEDBACK ON SERVICES/CARE
(specify) _____

NEXT SCHEDULED SUPERVISORY VISIT ___/___/___
CARE PLAN UPDATED? ❑ No ❑ Yes (specify) _____

If OT assistant/aide **not present,** specify date he/she was contacted regarding updated care plan: ___/___/___

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#

Form 3579/2P R103