

Agency: \_\_\_\_\_

### Occupational Therapy Progress Note

Visit:  Billable  Non-Billable Time In: \_\_\_\_\_ AM/PM Time Out: \_\_\_\_\_ AM/PM

Patient Name:		Patient Signature:	
<b>Treatment - Check All That Apply</b>			
<input type="checkbox"/> Evaluation <input type="checkbox"/> ADL Training <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Grooming <input type="checkbox"/> Feeding <input type="checkbox"/> Transfer Training			
<input type="checkbox"/> Muscle Re-Education <input type="checkbox"/> Establish-Upgrade Home Program <input type="checkbox"/> Perceptual Motor Training			
<input type="checkbox"/> Fine Motor Training <input type="checkbox"/> Neuro Development <input type="checkbox"/> Sensory Treatment <input type="checkbox"/> Orthotics/Splinting			
<input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Therapeutic Exercises <input type="checkbox"/> Balance Activities <input type="checkbox"/> Other:			
Primary Diagnosis:			
Functional Impairments:			
<input type="checkbox"/> Dyspnea on exertion			
Pain Assessment: <input type="checkbox"/> No pain		Location:	Duration:
# of hrs/mins since last pain med taken: _____			Intensity:

<b>Objective/Subjective Findings:</b>
<b>Treatment Provided/Plan of Care:</b>
<b>Plan:</b>
<b>Reason Homebound:</b> <input type="checkbox"/> Bedbound/Chair/Wheelchair bound <input type="checkbox"/> Requires assistive device <input type="checkbox"/> Unsteady gait/requires 1 or more people <input type="checkbox"/> Fatigue/poor endurance <input type="checkbox"/> Severe disabling pain <input type="checkbox"/> Needs assistance to leave the house safely.
<b>Coordination of Care:</b> <input type="checkbox"/> NA <input type="checkbox"/> Dr <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> COTA <input type="checkbox"/> ST <input type="checkbox"/> OTHER
Regarding: _____
<input type="checkbox"/> 5 day discharge notice given to patient/physician. Other: _____
Therapist's Signature/Date: _____ Supervisor: _____