Agency:_____

Occupational Therapy Progress Note

Visit: ☐ Billable ☐ Non-Billable Time In: _____AM/PM Time Out: _____AM/PM

Patient Name:	Patient Signature:

Treatment - Check All That Apply

☐ Evaluation ☐ ADL Training ☐ Bathing ☐ Dressing ☐ Grooming ☐ Feeding ☐ Transfer Training
☐ Muscle Re-Education ☐ Establish-Upgrade Home Program ☐ Perceptual Motor Training
☐ Fine Motor Training ☐ Neuro Development ☐ Sensory Treatment ☐ Orthotics/Splinning
☐ Adaptive Equipment ☐ Therapeutic Exercises ☐ Balance Activities ☐ Other:

Primary Diagnosis:

Functional Impairments:
☐ Dyspnea on exertion

Pain Assessment: ☐ No pain Location: Duration: Intensity:
# of hrs/mins since last pain med taken:_____

Objective/Subjective Findings:

Treatment Provided/Plan of Care:

Plan:

Reason Homebound: ☐ Bedbound/Chair/Wheelchair bound ☐ Requires assistive device ☐ Unsteady gait/requires 1 or more people ☐ Fatigue/poor endurance ☐ Severe disabling pain ☐ Needs assistance to leave the house safely.

Coordination of Care: ☐**NA** ☐**Dr** ☐**RN** ☐**PT** ☐**OT** ☐**COTA** ☐ **ST** ☐ **OTHER**
Regarding: _____

☐ 5 day discharge notice given to patient/physician. Other:_____

Therapist's Signature/Date: Supervisor: