

Patient Name: _____ **MR:** _____ **Visit Date:** _____
Episode/Period: _____ **Time In:** _____ **Time Out:** _____

Vital Signs						
SBP	DBP	HR	Resp	Temp	Weight	O2 Sat
125	73	78	16	97.8	_____	_____

Subjective

Pt pleasant and agreeable without c/o pain.

Homebound Reason

<input type="checkbox"/> Requires considerable and taxing effort. <input type="checkbox"/> Needs assist with transfer. <input type="checkbox"/> Needs assist leaving the home. <input type="checkbox"/> Severe SOB upon exertion.	<input type="checkbox"/> Medical restriction. <input type="checkbox"/> Needs assist with ambulation. <input type="checkbox"/> Unable to be up for long period. <input type="checkbox"/> Unsafe to go out of home alone.
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Functional Limitations/Problem Areas

Upper body Rom/strength deficit. Impaired safety. Difficulty with homemaking skills/money management/meal prep/laundry. Impaired coordination. Cognition (memory, safety awareness, judgement).	<input type="checkbox"/> Pain affecting function. <input type="checkbox"/> Difficulty with dressing/grooming/bathing/hygiene/toileting. <input type="checkbox"/> Impaired problem solving skills/attention/concentration/sequencing. <input type="checkbox"/> Visual deficit/disturbance/limitation.
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Pain Assessment

Pain Location _____ **Pain Level** _____ **0**
Increased by _____ **Relieved by** _____

Teaching

<input type="checkbox"/> Patient/Family <input type="checkbox"/> Safety Technique <input type="checkbox"/> Correct Use of Assistive Device	<input type="checkbox"/> Caregiver <input type="checkbox"/> ADLs	<input type="checkbox"/> Correct Use of Adaptive Equipment <input type="checkbox"/> HEP
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Other(modalities, DME/AE need, consults, etc): _____

ADL Training

I.FUNCTIONAL MOBILITY	Assistance	Assistive Device
Bed mobility	CGA = Contact Guard Assist	_____
Bed/WC transfers	_____	_____
Toilet transfer	_____	_____
Tub/shower transfer	_____	_____
Comment	_____	

Clinician Signature: _____ **Date:** _____
Co-Signature: _____ **Date:** _____

Patient Name:	MR:	Visit Date: 5/29/2018
Episode/Period: 04/11/2018 - 06/09/2018	Time In: 04:15 PM	Time Out: 04:45 PM

ADL Training

Comment

II.SELFCASE/ADL SKILLS	Assistance x Reps	Assistive Device x Reps
Self Feeding	___ x	___ x
Oral Hygiene	___ x	___ x
Grooming	___ x	___ x
Toileting	___ x	___ x
UB bathing	___ x	___ x
LB bathing	___ x	___ x
UB dressing	___ x	___ x
LB dressing	___ x	___ x
Comment		

III.INSTRUMENTAL ADL	Assistance	Assistive Device
Housekeeping	___ x	___ x
Meal prep	___ x	___ x
Laundry	___ x	___ x
Telephone use	___ x	___ x
Money management	___ x	___ x
Medication management	___ x	___ x
Comment		

	Static	Dynamic
Sitting Balance	___	___
Stand Balance	___	___

Therapeutic Exercise

ROM To:	BUE/BLE x 30 reps
Active To:	BUE/BLE x 30 reps
Active/Assistive To:	BLE x 30 reps
Resistive, Manual, To:	x reps
Resistive, w/Weights, To:	x reps
Stretching To:	BUE/BLE x 30 reps
Comment:	

Clinician Signature: Electronically Signed by: <i>[Signature]</i> COTA	Date: 5/29/2018
Co-Signature: Electronically Signed by: <i>[Signature]</i> OT	Date: 5/30/2018

Patient Name:	MR:	Visit Date: 5/29/2018
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Supervisory Visit(Complete if applicable)

OT Assistant
 Aide
 Present
 Not Present

Observation of:

Teaching/Training of:

Care plan reviewed/revised with assistant/aide during this visit:

Yes
 No

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

Therapeutic/Dynamic Activities

	Assistance x Reps	Assistive Device
Bed Mobility	CGA = Contact Guard Assist x	_____
Bed/WC transfer	_____ x	_____
Toilet transfer	_____ x	_____
Tub/Shower transfer	_____ x	_____
Other	_____ x	_____

Assessment

Pt is limited by generalized weakness, difficulty transferring, Max A for most ADLs and Dep for all IADLs

W/C Mobility

N/A

Level	_____ Uneven	_____
Maneuver	_____ ADL	_____

Plan

Continue Prescribed Plan _____
 Change Prescribed Plan _____

Plan Discharge _____

Comments

Progress made towards goals

Improved understanding of HEP

Skilled treatment provided this visit

Therapeutic exercise <input type="checkbox"/> Neuromuscular re-education <input type="checkbox"/> Teach fall prevention/safety Pt/caregiver education/training <input type="checkbox"/> Postural control training	Therapeutic activities (reaching, bending, etc) <input type="checkbox"/> Teach safe and effective use of adaptive/assist device Establish/upgrade home exercise program <input type="checkbox"/> Sensory integrative techniques Teach energy conservation techniques
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Clinician Signature: Electronically Signed by: *Arias Home Health* **Date:** 5/29/2018

Co-Signature: Electronically Signed by: *Arias Home Health* **Date:** 5/30/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
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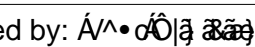
COTA Visit

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Skilled treatment provided this visit

- | | |
|---|---|
| <input type="checkbox"/> Wheelchair management training | <input type="checkbox"/> Teach safe and effective breathing technique |
| <input type="checkbox"/> Teach work simplification | <input type="checkbox"/> Community/work integration |
| <input type="checkbox"/> Self care management training | <input type="checkbox"/> Cognitive skills development/training |
| Teach task segmentation | Manual therapy techniques |
| <input type="checkbox"/> Electrical stimulation | Body Parts: _____ Duration: _____ |
| <input type="checkbox"/> Ultrasound | Body _____ Dosage: _____ Duration: _____ |
| | Parts: _____ |

Other

Clinician Signature: Electronically Signed by:  COTA

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