ŒÃãæ ÁP[{ ^ÁP^æþc@
I Ì FFÁÔ@ã]]^}åæþ^ÁÖ¦ÈÀG€F
Ùæ&lãæ{ ^}ç[ÊÁÔŒÁJÍ Ì I F
Ú@}^KÁÇJFÎ DÁJFHËFFHI ÁÁØæ¢KÁÇJFÎ DÁJHËJFGG

COTA Visit

Patient Name: **MR:** **Visit Date:** Í ÐGJÐG€FÌ

Episode/Period: €I ÐFFÐG€FÌ ÁËÁ€Î ÐEJÐG€FÌ **Time In:** €I KFÍ ÁÚT **Time Out:** €I KÍ ÁÚT

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

Requires considerable and taxing effort.
Needs assist with transfer.
Needs assist leaving the home.
☐ Severe SOB upon exertion.
☐ Medical restriction.
Needs assist with ambulation.
Unable to be up for long period.
Unsafe to go out of home alone.

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).
☐ Pain affecting function.
Difficulty with dressing/grooming/bathing/hygiene/toileting.
Impaired problem solving skills/attention/concentration/sequencing.
☐ Visual deficit/disturbance/limitation.

Pain Assessment

Pain Location ____ **Pain Level** 0

Increased by ____ **Relieved by** ____

Teaching

Patient/Family
☐ Safety Technique
☐ Correct Use of Assistive Device
☐ Caregiver
☐ ADLs
☐ Correct Use of Adaptive Equipment
HEP

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: Ò|^&d[}ã&æ|^ ÁÙã } ^åÁà^ K ÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁ ÁÚ VŒ **Date:** Í ÐGJÐG€FÌ

Co-Signature: Ò|^&d[}ã&æ|^ ÁÙã } ^åÁà^ K ÁÁÁ ÁÚ V **Date:** Í ÐH€ÐG€FÌ

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

COTA Visit

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: Á/^•cÁÔ|ã ãã) ÁOTA **Date:** 5/29/2018

Co-Signature: Electronically Signed by: ÁÁÁ/^•cÁÔ|ã ãã) ÁOT **Date:** 5/30/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

COTA Visit

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

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
Therapeutic activities (reaching, bending, etc)
☐ Neuromuscular re-education
☐ Teach safe and effective use of adaptive/assist device
☐ Teach fall prevention/safety
Establish/upgrade home exercise program
Pt/caregiver education/training
☐ Sensory integrative techniques
☐ Postural control training
Teach energy conservation techniques

Clinician Signature: Electronically Signed by: Á/^•cÓÔ|ã ãæ ÓOTA **Date:** 5/29/2018

Co-Signature: Electronically Signed by: ÁÁÁ/^•cÓÔ|ã ãæ ÓOT **Date:** 5/30/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

COTA Visit

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

Skilled treatment provided this visit

☐ Wheelchair management training
☐ Teach work simplification
☐ Self care management training
Teach task segmentation
☐ Electrical stimulation
☐ Ultrasound

☐ Teach safe and effective breathing technique
☐ Community/work integration
☐ Cognitive skills development/training
Manual therapy techniques
Body Parts: ______________ **Duration:** ______________
Body Parts: _________ **Dosage:** _________ **Duration:** _________

Other

Clinician Signature:
Date: 5/29/2018

Co-Signature:
Date: 5/30/2018