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

OT Visit

Patient Name: Test Patient **MR:** #### **Visit Date:** 6/7/2018

Episode Period: 05/08/2018 - 07/06/2018 **Time In:** 06:00 AM **Time Out:** 06:30 AM

Associated Mileage: **Surcharge:** **Physician:** Test Physician M.D.

Vital Signs

SBP	DBP	HR	Resp	Temp	Weight	O2 Sat
115	78	70	12			

Subjective

A/O x 1, able to follow instructions intermittently

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 NA **Pain Level** 0

Increased by _____ **Relieved by** _____

Teaching

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

Other(modalities, DME/AE need, consults, etc): _____

ADL Training

I.FUNCTIONAL MOBILITY	Assistance	Assistive Device
Bed mobility	____	____
Bed/WC transfers	____	____
Toilet transfer	____	____
Tub/shower transfer	____	____

Comment

Clinician Signature: Electronically Signed by: Test Clinician OT

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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:	x reps
Active To:	x reps
Active/Assistive To:	x reps
Resistive, Manual, To:	x reps
Resistive, w/Weights, To:	x reps
Stretching To:	x reps

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Therapeutic Exercise

Comment:
Upgrade HEP for facilitating PROM of the LUE in all planes of motion to reduce hyperonicity and promote purposeful movement. Patient tolerated tx well with no signs of pain either verbal or non verbal. Continue OT Care Plan.

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	____ x	____
Bed/WC transfer	____ x	____
Toilet transfer	____ x	____
Tub/Shower transfer	____ x	____
Other	____ x	____

Assessment

Upgrade HEP for facilitating PROM of the LUE in all planes of motion to reduce hyperonicity and promote purposeful movement. Patient tolerated tx well with no signs of pain either verbal or non verbal. Continue OT Care Plan.

W/C Mobility

☐ N/A

Level _____ **Uneven** _____

Maneuver _____ **ADL** _____

Plan

Continue Prescribed Plan _____ **Change Prescribed Plan** _____

Plan Discharge _____

Comments

_____

Progress made towards goals

Upgrade HEP for facilitating PROM of the LUE in all planes of motion to reduce hyperonicity and promote purposeful movement. Patient tolerated tx well with no signs of pain either verbal or non verbal. Continue OT Care Plan.

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Skilled treatment provided this visit

Therapeutic exercise

☐ Neuromuscular re-education
☐ Teach fall prevention/safety
☐ Pt/caregiver education/training
☐ Postural control training
☐ Wheelchair management training
☐ Teach work simplification
☐ Self care management training
☐ Teach task segmentation
☐ Electrical stimulation
☐ Ultrasound

Therapeutic activities (reaching, bending, etc)

☐ Teach safe and effective use of adaptive/assist device
☐ Establish/upgrade home exercise program
☐ Sensory integrative techniques
☐ Teach energy conservation techniques
☐ 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:**

Electronically Signed by: Test Clinician OT 6/7/2018