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

# OT Plan Of Care

**Patient Name:** Test Patient **MR:** xxxx **DOB:** xx/xx/xxxx

**Episode Period:** 06/05/2018 - 08/03/2018 **Physician:** Test Physician **Order#:** xxxxxxxx

## DME

☐ N/A

**Available:** W/C, Mechanical Lift

**Needs:** _____

**Suggestion:** _____

## Diagnosis

**Medical Diagnosis:** CVA with R Hemiplegia **Onset** _____

**OTDiagnosis:** Muscle weakness **Onset** _____

**Comment**

_____

## Treatment Plan

**OT Frequency & Duration:**

2w1, 3 w 2, 1 w 1 eff 6/7

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**

_____

## Modalities

☐ N/A

_____

_____

## OT Goals

**Additional Goals:**

_____

**Clinician Signature:** **Date:**

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

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

# OT Plan Of Care

**Patient Name:** Test Patient **MR:** xxxx **DOB:** xx/xx/xxxx

**Episode Period:** 06/05/2018 - 08/03/2018 **Physician:** Test Physician **Order#:** xxxxxxxx

## OT Goals

**OT Short Term Goals:**

Min bed mobility rolling side to side

Min bed mob supine to EOB

Patient and staff to return demo understanding of HEP for PROM of RUE, AAROM of RUE where indicated

4/5 LUE strength

Mod I grooming and hygiene, self feeding with AE PRN

**OT Long Term Goals:**

Meet STGs

**Rehab Potential:**

## Other Discipline Recommendation

☐ N/A

☐ PT ☐ MSW ☐ ST ☐ Podiatrist **Other** _____

**Reason**

## Rehab

☐ N/A

**Rehab Diagnosis:** Muscle weakness

**Rehab Potential:** ☐ Good ☐ Fair ☐ Poor

## Discharge Plan

☐ N/A

**Patient to be discharged to the care of** ☐ Physician Caregiver ☐ Selfcare

**Discharge Plans** ☐ Discharge when caregiver willing and able to manage all aspects of patient's care. ☐ Discharge when goals met.

## Skilled Care Provided

☐ N/A

**Training Topics**

**Trained:** ☐ Patient ☐ Caregiver

**Clinician Signature:** **Date:**

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

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

# OT Plan Of Care

**Patient Name:** Test Patient **MR:** xxxx **DOB:** xx/xx/xxxx

**Episode Period:** 06/05/2018 - 08/03/2018 **Physician:** Test Physician **Order#:** xxxxxxxx

## Skilled Care Provided

**Treatment Performed:**

Facilitate home safety assessment with recommendations RE safety

**Patient Response:**

Return demo understanding with consistent cueing

| Care Coordination | Safety Issues/Instruction/Education |
|---|---|
| ☐ N/A<br>COTA RE CARE PLAN | ☐ N/A |

## Notification

Patient Caregiver

**Understands diagnosis/prognosis and agrees with Goals/Time frame and Plan of Care (POC)**

☐ Yes ☐ No

☐ Physician notified and agrees with POC, frequency and duration. Comments (if any):

## Treatment Performed

## Narrative

**Physician Signature** **Date**

**Clinician Signature:** **Date:**

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