

OCCUPATIONAL THERAPY REVISIT NOTE

Patient Name: _____ Date: ____ / ____ / ____ Time In: ____ am/pm Out: ____ am/pm
 Agency Name: _____ DOB: ____ / ____ / ____ Male Female

Is the patient still homebound? Yes _____ No _____ Reason: _____

Clinical Findings:

Vitals: Pulse: ____/min BP: ____/____

Pain Assessment: Pain Severity Level: 0 1 2 3 4 5 6 7 8 9 10 Location: _____

Functional Assessment: Functional Independence Measure (FIM) Scale

Functional Activities	Current Functional Status								Comments and Training Date
	Ind 1	Mod 2	Dep 3	Mod 4	Dep 5	Mod 6	Dep 7	Mod 8	
Feeding									
Dressing									
Grooming									
Upper body dressing									
Lower body dressing									
Toileting									
Meal preparation									
Housekeeping skills									

Functional Mobility	Current Functional Status								Comments and Training Date
	Ind 1	Mod 2	Dep 3	Mod 4	Dep 5	Mod 6	Dep 7	Mod 8	
Supine to sit									
Sit to stand									
Bed to chair									
Transfer/BSC									
Bedroom /bathroom									

Functional Goals	Met	Progressing	Not Progressing	None

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Annelies Wilder-Smith

A red circular graphic with a gradient, appearing as a partial circle or a stylized arrow pointing to the right, located to the right of the author's name.

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