

Agency: \_\_\_\_\_

## Occupational Therapy Progress Note

Visits: ☐ Billable ☐ Non-Billable Time In: \_\_\_\_\_ AM/PM Time Out: \_\_\_\_\_ AM/PM

Patient Name: _____		Patient Signature: _____	
<b>Treatment - Check All That Apply</b>			
<input type="checkbox"/> Evaluation <input type="checkbox"/> ADL Training <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Grooming <input type="checkbox"/> Feeding <input type="checkbox"/> Transfer Training			
<input type="checkbox"/> Muscle Re-Education <input type="checkbox"/> Establish/Upgrade Home Program <input type="checkbox"/> Perceptual Motor Training			
<input type="checkbox"/> Fine Motor Training <input type="checkbox"/> Neuro Development <input type="checkbox"/> Sensory Treatment <input type="checkbox"/> Orthotics/Splinting			
<input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Therapeutic Exercises <input type="checkbox"/> Balance Activities <input type="checkbox"/> Other: _____			
Primary Diagnosis: _____			
Functional Impairments: _____			
<input type="checkbox"/> Dyspnea on exertion			
Pain Assessment: <input type="checkbox"/> No pain Location: _____		Duration: _____	Intensity: _____
# of hrs/mins since last pain med taken: _____			

### Objective/Subjective Findings:


### Treatment Provided/Plan of Care:


### Plan:

**Reason Homebound:** ☐ Bedbound/Chair/Wheelchair bound ☐ Requires assistive device ☐ Unsteady gait/requires 1 or more people ☐ Fatigue/poor endurance ☐ Severe disabling pain ☐ Needs assistance to leave the house safely.

**Coordination of Care:** ☐ NA ☐ Dr ☐ RN ☐ PT ☐ OT ☐ COTA ☐ ST ☐ OTHER

Regarding: \_\_\_\_\_

☐ 5 day discharge notice given to patient/physician. Other: \_\_\_\_\_

Therapist's Signature/Date: \_\_\_\_\_

Supervisor: \_\_\_\_\_

# Occupational Therapy Progress Note Form

**KJ Lindholm-Leary**



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## **Table of Contents Occupational Therapy Progress Note Form**

1. Understanding the eBook Occupational Therapy Progress Note Form
  - The Rise of Digital Reading Occupational Therapy Progress Note Form
  - Advantages of eBooks Over Traditional Books
2. Identifying Occupational Therapy Progress Note Form
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Occupational Therapy Progress Note Form
  - User-Friendly Interface
4. Exploring eBook Recommendations from Occupational Therapy Progress Note Form
  - Personalized Recommendations
  - Occupational Therapy Progress Note Form User Reviews and Ratings

- Occupational Therapy Progress Note Form and Bestseller Lists
- 5. Accessing Occupational Therapy Progress Note Form Free and Paid eBooks
  - Occupational Therapy Progress Note Form Public Domain eBooks
  - Occupational Therapy Progress Note Form eBook Subscription Services
  - Occupational Therapy Progress Note Form Budget-Friendly Options
- 6. Navigating Occupational Therapy Progress Note Form eBook Formats
  - ePub, PDF, MOBI, and More
  - Occupational Therapy Progress Note Form Compatibility with Devices
  - Occupational Therapy Progress Note Form Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Occupational Therapy Progress Note Form
  - Highlighting and Note-Taking Occupational Therapy Progress Note Form
  - Interactive Elements Occupational Therapy Progress Note Form
- 8. Staying Engaged with Occupational Therapy Progress Note Form
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Occupational Therapy Progress Note Form
- 9. Balancing eBooks and Physical Books Occupational Therapy Progress Note Form
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Occupational Therapy Progress Note Form
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Occupational Therapy Progress Note Form
  - Setting Reading Goals Occupational Therapy Progress Note Form
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Occupational Therapy Progress Note Form
  - Fact-Checking eBook Content of Occupational Therapy Progress Note Form
  - Distinguishing Credible Sources

13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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