

Agency: _____

Occupational Therapy Progress Note

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

Patient Name: _____		Patient Signature: _____	
Treatment - Check All That Apply			
<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

Lei Shi

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 name bar.

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