

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:

|  |
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|  |
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|  |

### 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

**Victor M. Corman**

A red circular graphic with a gradient, appearing as a partial circle or a stylized 'C' shape, located to the right of the name bar.

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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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