

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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Occupational Therapy Revisit Note Form

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Monica, Pamela Boyd**



Occupational Therapy Revisit Note Form:

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