HEALING HANDS HOME HEALTH CARE

OCCUPATIONAL THERAPY CLINICAL NOTE

Client Name_____ ID#_____ Date_____ Time in:_____

SUBJECTIVE:_____ Time Out:_____

_____

_____

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SERVICES PROVIDED:

☐ ADL/Self Care_____ ☐ Functional mobility_____ ☐ Fine Motor Coordination_____

☐ Neuromuscular Re-ed_____ ☐ Sensory Treatment_____ ☐ Perceptual Motor Training_____

☐ Orthotics /Splinting_____ ☐ Adaptive/Compensatory_____ ☐ Home Program_____

☐ Other_____ ☐ Neuro Developmental Treatment_____

☐ Equipment Recommendations_____

☐ Patient/Caregiver teaching_____

☐ Understands_____ ☐ Incomplete knowledge_____ ☐ No knowledge_____

FUNCTIONAL STATUS	INDEP	V/C	SBA	CGA	MIN.	MOD.	MAX.	ASSIST DEVICE	COMMENTS

SENSORIMOTOR/STRENGTH	P	A/A	A
ROM:	P	A/A	A
STRENGTH:	LBS.	REPS.	
COORDINATION:	LBS.	REPS.	
	LBS.	REPS.	

MISC. (*sensory, safety, perception, cognition, other*):

RESPONSE TO CARE/INSTRUCTIONS:

HOME PROGRAM RECOMMEDATIONS/TYPE

Instructed: Pt. ☐ Caregiver ☐ Understands ☐ Incomplete ☐

EQUIPMENT/ORTHOTICS/ADAPTATIONS_____

_____

HOMEBOUND STATUS:

CARE COORDINATION

RN ☐ COTA ☐ HHA ☐ TEAM LEADER ☐ PHYSICIAN ☐

PT ☐ ST ☐ PATIENT ☐ CAREGIVER ☐ AGENCY ☐ OTHER ☐_____

Re:_____

Visit Frequency _____ Change ☐ Patient/Family Informed ☐

Supervisory Visit:_____

DISCHARGE PLAN:_____

Therapist Signature _____ Client Signature: _____