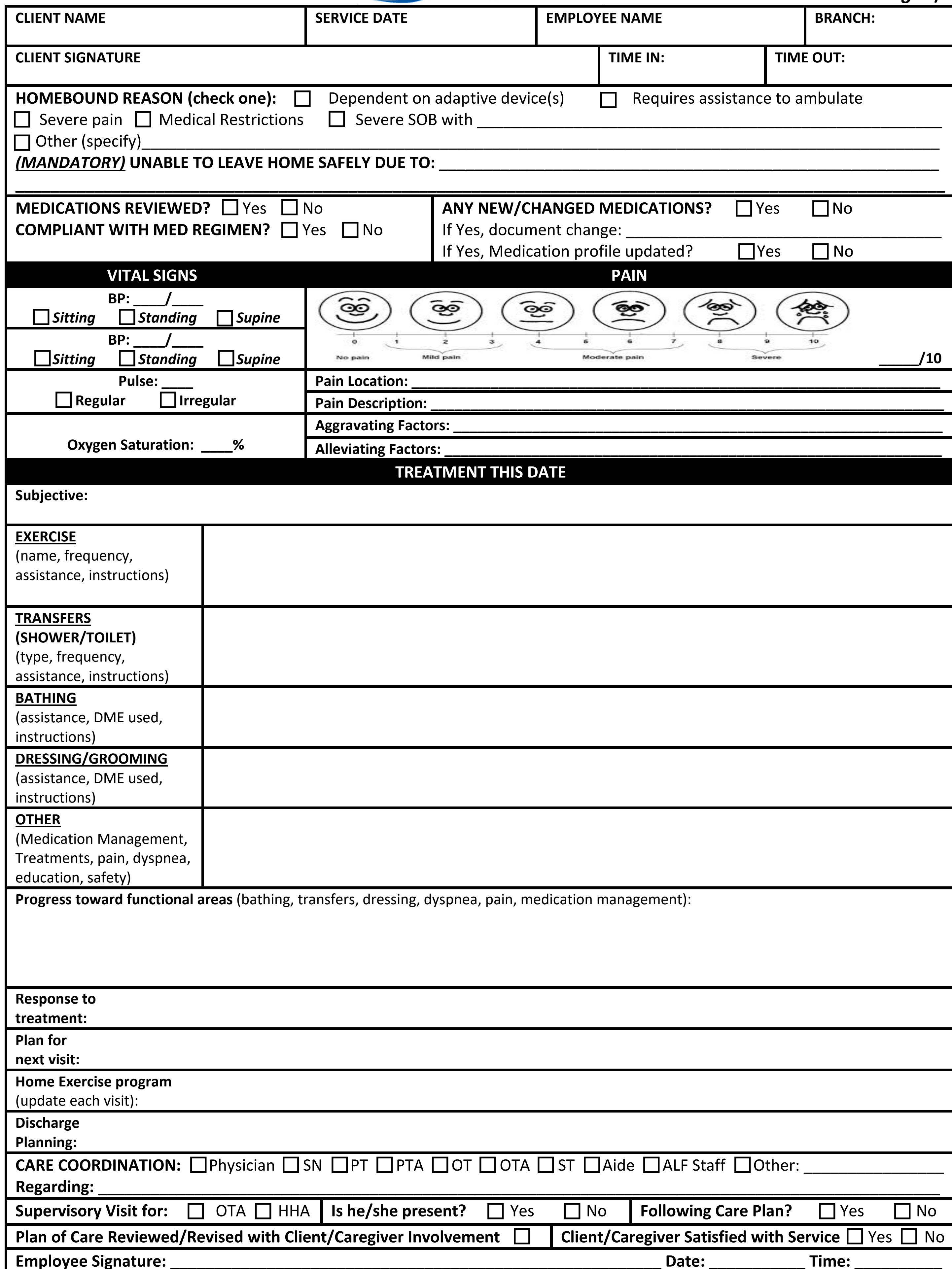

RecoverHealth
We bring health care home

OCCUPATIONAL THERAPY TREATMENT

CLIENT NAME	SERVICE DATE	EMPLOYEE NAME	BRANCH:
CLIENT SIGNATURE		TIME IN:	TIME OUT:

HOMEBOUND REASON (check one): ☐ Dependent on adaptive device(s) ☐ Requires assistance to ambulate
☐ Severe pain ☐ Medical Restrictions ☐ Severe SOB with ______
☐ Other (specify)______
(MANDATORY) **UNABLE TO LEAVE HOME SAFELY DUE TO:** ______

MEDICATIONS REVIEWED? ☐ Yes ☐ No **COMPLIANT WITH MED REGIMEN?** ☐ Yes ☐ No	**ANY NEW/CHANGED MEDICATIONS?** ☐ Yes ☐ No If Yes, document change: ______ If Yes, Medication profile updated? ☐ Yes ☐ No

VITAL SIGNS	PAIN
BP: ____/____ ☐ *Sitting* ☐ *Standing* ☐ *Supine*	0 1 2 3 4 5 6 7 8 9 10 No pain, Mild pain, Moderate pain, Severe ____/10
BP: ____/____ ☐ *Sitting* ☐ *Standing* ☐ *Supine*	
Pulse: ____ ☐ Regular ☐ Irregular	Pain Location: ______ Pain Description: ______
Oxygen Saturation: ____%	Aggravating Factors: ______ Alleviating Factors: ______

TREATMENT THIS DATE

Subjective:	
EXERCISE (name, frequency, assistance, instructions)	
TRANSFERS (SHOWER/TOILET) (type, frequency, assistance, instructions)	
BATHING (assistance, DME used, instructions)	
DRESSING/GROOMING (assistance, DME used, instructions)	
OTHER (Medication Management, Treatments, pain, dyspnea, education, safety)	

Progress toward functional areas (bathing, transfers, dressing, dyspnea, pain, medication management):

Response to treatment:

Plan for next visit:

Home Exercise program (update each visit):

Discharge Planning:

CARE COORDINATION: ☐ Physician ☐ SN ☐ PT ☐ PTA ☐ OT ☐ OTA ☐ ST ☐ Aide ☐ ALF Staff ☐ Other: ______
Regarding: ______

Supervisory Visit for: ☐ OTA ☐ HHA | **Is he/she present?** ☐ Yes ☐ No | **Following Care Plan?** ☐ Yes ☐ No

Plan of Care Reviewed/Revised with Client/Caregiver Involvement ☐ | **Client/Caregiver Satisfied with Service** ☐ Yes ☐ No

Employee Signature: ______ **Date:** ______ **Time:** ______