1 Patient Information

1 PATIENT DETAILS

Name: _____ Date of Service: _____

DOB: _____ Occupational Therapist: _____

Age / Sex: _____ MRN: _____

Referring Provider: _____ Visit Type: _____

Care Setting: _____ Primary Diagnosis / Reason for OT Referral: _____

RN Reason for Occupational Therapy

2 PRIMARY FUNCTIONAL CONCERN

Primary functional concern requiring OT — limitations in ADLs, IADLs, upper extremity function, cognition, safety, sensory processing, or return-to-work/school participation...

S Subjective

3 PATIENT-REPORTED CONCERNS, GOALS & LIMITATIONS

3a CURRENT FUNCTIONAL CONCERNS

Self-care, dressing, bathing, grooming, toileting, feeding, cooking, writing, driving, work, school, leisure, or household tasks...

3b ONSET & COURSE / PRIOR LEVEL OF FUNCTION

Onset / Related condition: _____ Prior Level of Function (baseline independence): _____

3c PAIN / SENSORY SYMPTOMS

Pain location / severity / quality: _____ Numbness / tingling / hypersensitivity / weakness: _____

3d HOME / WORK / SCHOOL ENVIRONMENT & PATIENT GOALS

Environmental barriers / caregiver support / accessibility: _____ Patient-centered goals: _____

O Objective

4 MEASURABLE OT FINDINGS

V VITALS (IF APPLICABLE)

Blood Pressure: _____ Heart Rate: _____

O2 Saturation: _____ Pain Score: _____

4a FUNCTIONAL ASSESSMENT — LEVEL OF ASSISTANCE

Feeding: _____ Grooming: _____

Bathing: _____ Dressing: _____

Toileting: _____ Functional Transfers: _____

Bed Mobility: _____ Meal Prep / Household: _____

Work / School Tasks: _____

4b UPPER EXTREMITY ASSESSMENT

Range of Motion: _____ Strength: _____

Coordination: _____ Fine Motor Skills: _____

Grip / Pinch Strength: _____ Edema: _____

Sensation: _____ Hand Dominance: _____

4c COGNITIVE / PERCEPTUAL ASSESSMENT

Attention: _____ Memory: _____

Problem-Solving: _____ Sequencing: _____

Visual-Perceptual: _____ Safety Awareness / Judgment: _____

4d BALANCE / MOBILITY RELATED TO ADLS

Sitting/standing balance, transfer safety, endurance, fall risk, assistive device use as it affects occupational performance...

SA Standardized Assessment Tools

5 ASSESSMENT SCORES

AM-PAC / 6-Clicks Daily Activity: _____ Barthel Index: _____

Functional Independence Measure: _____ DASH / QuickDASH: _____

COPM: _____ Nine-Hole Peg Test: _____

MoCA / Cognitive Screen: _____ Other (pediatric / sensory): _____

IN Interventions Provided

6 OT SERVICES DELIVERED

ADL training, therapeutic activities, therapeutic exercises, neuromuscular re-education, fine motor/coordination training, cognitive retraining, energy conservation, adaptive equipment training, splinting/orthotic management, home safety education, caregiver training...

RI Response to Intervention

7 PATIENT RESPONSE

Participation and tolerance, level of cueing or assistance required, improvement/fatigue/pain/barriers, carryover of education, safety during tasks...

A Assessment

8 OT CLINICAL INTERPRETATION

Occupational performance deficits, impairments affecting function, rehabilitation potential, barriers to progress, safety concerns, medical necessity for continued skilled OT services...

P Plan

9 OT MANAGEMENT

9a FREQUENCY, DURATION & GOALS

OT Frequency / Duration: _____ Functional Goals to Target: _____

9b HOME PROGRAM & EQUIPMENT

Home exercise or activity program. Adaptive equipment or environmental modification recommendations...

9c COORDINATION & EDUCATION

Caregiver education, coordination with PT/SLP/nursing/physician/school/employer/case management...

GL Goals

10 MEASURABLE OT GOALS

10a SHORT-TERM GOALS

Functional goals expected within next treatment interval...

10b LONG-TERM GOALS

Goals related to independence, safety, return to prior level of function, or meaningful participation...

FU Follow-Up

11 NEXT OT VISIT & REASSESSMENT

Next OT Visit: _____ Reassessment Timeline: _____

Discharge Criteria: _____ Physician Follow-Up Needed: _____

TIME DOCUMENTATION & BILLING (OT)

Total Treatment Time: ____ Timed Code Minutes: ____ Evaluation Code (97165/97166/97167): _____ Treatment Code(s) (97535/97530/97110/97112): _____

Basis for Billing: _____ Primary ICD-10 Code: _____

Secondary ICD-10 Code(s): _____

OCCUPATIONAL THERAPIST NAME	CREDENTIALS	DATE	TIME