[Company Name] Occupational Therapy Note

Patient Name:							Patient ID:					Branch:	
Start Visit Time:	End Visit Time:						Total Time:					SOC:	
Primary Diagnosis:													Onset:
Pain: ☐ Yes ☐ No Scale 1-1			□ 3	□ 4	□ 5		5 🗆	7 [∃8	□9	□ 10	Relieved	W/Med? □ Yes □ No
Agency Notified? □ Yes □ No	Locat	ion:											
Homebound Status:													1
Universal Precautions:	-Hazard	Bag		Gown	Ш	Mas	k	Ц	ogg	gles	☐ Antiba	acterial Ha	nd Washing
Limitations Requiring Occupati	onal The	erapy	(SOA)):									
Skilled Inventions/Treatments:													
()													
()													
()													
()													
()													
Patient/Caregiver Response to	Treatme	ent:											
Short Term Plan and Date for Next Treatment:													
Coordinated Services with Who	m?												
Supervisory Visit Performed by OT of COTA: Are goals being met? Yes										No	COTA P	resent?	l Yes 🗆 No
Following Plan of Care? ☐ Yes	□ No	Rela	ations	hip Tl	nerape	eutic	:? [] Ye	s \square	l No	Uses Un	iversal Pre	cautions? Yes No
Report from Patient/Caregiver	•												
						-							
PATIENT'S SIGNATURE:							THE	RAPI	ST'S	SIGN	IATURE:		
DATE:							DAT	E:					