[Company Name]
Home Health Occupational Therapist Daily Visit Record

Patient Name			Therapist Signature		
			Patient Signature		
			Patient ID Number	Date	Type of Visit
Arrival Time	Leaving Time	Total Time			
DME or Appliance in Use:					
Comments/Observations/Mental Status:					
Interventions:					
Beginning Mileage	Ending Mileage	Travel Time	Service Time	Other Time	

Revised: _____