OCCUPATIONAL THERAPY ASSESSMENT AND PLAN OF CARE

Diagnosis: _____ Pt. Name: _____
ID #: _____

Impairment list with functional limitations:

- □ Impaired Self Care / ADL instruction
- □ Perceptual Motor Deficit
- □ Impaired Fine Motor Skills
- □ Decreased Independence with Homemaking Skills
- □ Decreased Endurance
- □ Potential/actual needs for adaptive equipment
- □ Potential/actual pain
- □ Impaired UE ROM/Strength
- □ Impaired ROM/Strength
- □ Other: _____

Treatment Plan:

- □ Evaluation
- □ Self Care / ADL instruction
- □ UE ROM and strengthening
- □ Perceptual Motor Training
- □ Fine Motor Skills Re-Education
- □ Neuromuscular Re-Education
- □ Compensatory Strategies
- □ Adaptive Homemaking Instruction
- □ Fabrication of/training with orthotics/splints
- □ Assess Adaptive Equipment Needs
- □ Energy Conservation Training/Work Simplification
- □ Joint Protection Skill Instruction
- □ Home Program Instruction or Upgrade
- □ Equipment Assessment
- □ Transfer/Mobility Training
- □ Other: _____

Goals:

- □ Patient will demonstrate no new or worsening symptoms
- □ Patient will maintain condition in home without hospitalization, ER visit or unplanned physician visits
- □ Patient will verbalize adverse signs/symptoms to report
- □ Patient/Caregiver will verbalize potential complications related to decreased mobility
- □ Patient will demonstrate appropriate/safe use of assistive devices so able to…_____
- □ Patient will demonstrate improved □ UE, □ LE, □ general strength so able to…_____
- □ Patient will demonstrate improved _____ROM to □functional so able to…_____
- □ Patient will demonstrate improved perceptual motor skills so able to… _____
- □ Patient will demonstrate improved fine motor skills so able to… _____
- □ Patient will demonstrate joint integrity and improvement of function through use of splints/slings
- □ Patient will demonstrate maximum level of independence with self care/ADL skills/homemaking skills
- □ Patient will perform HEP □ independently, □ with assist from _____
- □ Patient will demonstrate decreased pain, allowing an increase in functional activity
- □ Patient will demonstrate independence in energy conservation/work simplification so able to..._____
- □ Patient will demonstrate adequate motivation toward achieving an increased level of function
- □ Other: _____
- □ Other: _____

Rehab Potential: _____ Rationale:_____

Verbal Order obtained: □ yes □ no Written order obtained: □ yes □ no
OT Visit Frequency: _____

D/C Plans:_____

Clinician Signature:_____ Date:_____

Physician Signature:_____ Date:_____