**OCCUPATIONAL THERAPY REVISIT NOTE**

**DATE OF SERVICE** / /
**TIME IN**
**TIME OUT**

**VITAL SIGNS:**
- Temp: ________
- Pulse: ________
- Respiration: ________
- B/P: ________

Using O₂ at ________LPM via:

**PAIN:**
- Rating scale: 0 1 2 3 4 5 6 7 8 9 10
- Current pain level: ________

**Treatment Diagnosis/Problem Area(s):**
- Coordination deficits (Fine/Gross)
- Upper body weakness/limited ROM
- Visual disturbances/deficits/limitations

**GOALS/OUTCOMES:**
- Patient/Caregiver/Therapist identified functional based goals (areas identified in evaluation)

**Functional Goal Area**
- Performance/Progress toward Functional Task:
- Barriers towards Independence:

**CARE PLAN:**
- Reviewed/Revised with Patient/Caregiver/Family

**APPROXIMATE NEXT VISIT DATE:** / /

**DISCHARGE PLAN DISCUSSED WITH:**
- Patient
- Family
- Care Manager
- Physician
- Other:

**BILLABLE SUPPLIES USED?**
- N/A
- Yes (specify)

**CARE COORDINATION DISCUSSED WITH:**
- Physician
- Nursing
- PT
- OT
- ST
- MSW
- Aide
- Other:

**COMMENTS:**

_____________________________________________________________________________________________________________________________________

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**SIGNATURES/DATES**

X

Patient/Caregiver (if applicable) Date / /  Complete TIME OUT (above) prior to signing below.

Therapist (signature/title) Date / / /

**PATIENT NAME** – Last, First, Middle Initial

ID#