MUSC Health

*PRGRECRD*

# Occupational Therapy Progress Note



Form Origination Date: 5/09
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**Patient Name** _____
**MRN** _____
**PATIENT IDENTIFICATION LABEL**

Total treatment time _____ min Pain level _____/10 ☐ unable to report pain Vital signs _____
Family members present : ☐ spouse ☐ sibling ☐ mother ☐ father ☐ none ☐ other _____

**Subjective:** _____

**Objective:**

**key for patient assistance:**
**TA** = total assist < 25% **Max** – maximum assistance 25%-50% **Mod** – moderate assistance 50%-75% **Min** – minimum assistance > 75%
**S–** supervision, standby, set / up, cues **MI** – modified independence – use of equipment or increased time **I** – independent

| | TA | MAX | MOD | MIN | S | MI | I | | TA | MAX | MOD | MIN | S | MI | I |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Feeding | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Rolling | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grooming | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Supine to sit | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| UB bathing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Transfer Chair | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| LB bathing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Transfer Toilet | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| UE dressing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Toileting | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| LE dressing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments: _____

Cognition ☐ intact ☐ impaired (explain) _____
Splints ☐ R ☐ L ☐ hand ☐ wrist ☐ elbow ☐ LE ☐ other _____
wearing schedule _____
Tone: ☐ R ☐ L ☐ normal ☐ hypertonic ☐ hypotonic comments _____
Education / Equipment provided ☐ exercises ☐ DME / adaptive equipment ☐ hip precautions ☐ brace ☐ safety education
☐ patient ☐ caregiver ☐ expressed understanding ☐ demonstrated understanding ☐ needs reinforcement

**Assessment / Goals:** _____

**Discharge Recommendations:** ☐ Home ☐ Home Health OT ☐ Acute Rehab ☐ SNF ☐ LTAC ☐ Outpatient OT
☐ 24 Hour Supervision ☐ other: _____

**Equipment for D/C:** ☐ bedside commode ☐ shower chair ☐ tub transfer bench ☐ other _____
☐ shoe horn ☐ sponge ☐ reacher ☐ sock-aid

**Plan:** Continue OT per Plan of Care: _____ X per week _____ X per day

At end of session, patient has the following within reach: ☐ bedside table ☐ call bell ☐ telephone

At end of session, patient: ☐ has bed alarm activated ☐ has chair alarm activated ☐ in chair, nursing notified.

Signature _____ Pager ID _____ Date ____/____/____ Time _____ AM/PM