

Occupational Therapy Documentation Cheat Sheet

Patient Information:

- Full name, date of birth, contact information
- Referring physician or healthcare provider
- Insurance information

Occupational Profile:

- Client's occupations, roles, and routines
- Client's goals and priorities
- Client's strengths and limitations

Assessment Section:

- Objective measurements (e.g., ROM, strength)
- Subjective observations (e.g., pain level, client's response)

Intervention:

- Specific interventions used during therapy sessions
- Therapeutic activities and exercises
- Home exercise program recommendations

Progress Notes:

- Client's progress towards goals
- Any changes in treatment plans
- Client's response to interventions

Documentation Tips:

- Be concise and relevant, avoid unnecessary details
- Use SOAP note format (Subjective, Objective, Assessment, Plan)
- Sign and date each entry for accountability

Legal and Compliance:

- Ensure documentation meets regulatory standards
- Protect client confidentiality at all times

Additional Resources:

- AOTA's Guidelines for Occupational Therapy Documentation
- Sample documentation templates for reference

Follow-Up:

- Schedule follow-up appointments as needed
- Provide clients with resources for continued self-care

Remember: Accurate documentation is essential for providing quality care, communicating effectively with other healthcare professionals, and ensuring proper reimbursement.

Occupational Therapy Documentation

Therapist Name: **Session Date:**

Patient Information:

- Name:
- DOB:
- Contact:
- Referring Physician:
- Insurance:

Occupational Profile:

-
- Goals:

- Strengths:

Assessment Section:

- Objective:
- Subjective:

Intervention:

- Therapeutic Activities:
- Therapeutic Exercises:
- Home Exercise Program:

Progress Notes:

-
-
-

Documentation Tips:

-
-
-

Legal and Compliance:

-
-

Follow-Up:

-
-

Remember: Accurate documentation supports effective care delivery and ensures continuity in treatment plans.