

Occupational Therapy Home Assessment

Patient Information

Name:

Date of Birth:

Address:

Contact Number:

Emergency Contact:

Referring Physician/Healthcare Provider

Name:

Contact Information:

Reason for Referral

Assessment Components

1. Daily Living Activities

2. Home Environment

3. Cognitive Function

4. Mobility and Physical Skills

5. Assistive Devices

6. Family/Caregiver Input

Intervention Plan

1. Goals

Short-term:

Long-term:

2. Interventions

3. Education

4. Follow-Up

Additional Recommendations

Provider Signature

Name:

Date: