Occupational Therapy Treatment Plan

Client Information
Name:
Date of Birth:
Address:
Phone Number:
Emergency Contact:
Referring Physician:
Date of Initial Evaluation:
Medical and Therapy History
Primary Diagnosis:
Secondary Diagnosis:
Previous Therapies and Outcomes:
Relevant Surgical History:
Medications:
Allergies:

Assessment Summary
Cognitive Function:
Physical Abilities:
Sensory Functions:
Emotional / Behavioral State:
Communication Skills:
Social Skills:
Environmental Factors:
Activities of Daily Living (ADLs) Performance:
Instrumental Activities of Daily Living (IADLs) Performance:

Goals
Short-Term Goals:
Long-Term Goals:
Intervention Plan
Therapeutic Activities:
Adaptive Techniques and Equipment

Environmental Modifications

Caregiver / Family Training

Implementation Schedule

Progress Review and Modifications

Discharge Planning
Achievements:
Recommendations for Continued Care:
Follow-up Appointments:
Professional's Signature
Name:
Title:
Date:
Client / Caregiver Acknowledgement
Name:
Relationship to Client:
Date: