matrix
The Primary Source for Home Care

Occupational Therapy Plan of Care

PHYSICIAN PLAN OF CARE - CHANGE AND ADDITIONAL ORDERS

Patient/Client Name: _____ Date: _____

Patient/Client Address: _____

Physician's Name: _____

Physician's Phone: _____ Fax: _____

County: _____

Dear Doctor:
The orders shown below are being forwarded for your signature to authorize your verbal orders given on this date. Please sign and return this form within three (3) days for our patient's chart. *Thank you for the referral of your patient for services.*

❒ Initial Evaluation ❒ Routine Visit
❒ Frequency/Duration _____ AS OF Date ____/____/____

OT Evaluation Date:__/__/__
❒ To evaluate

ADL Training
OT to provide training in:
❒ Hygiene skills
❒ Dressing skills
❒ Feeding skills
❒ Homemaking skills
❒ Leisure skills
_____
_____

Muscle Re-Education
OT to provide:
❒ Facilitatory/Inhibitory exercises
_____
_____

Perceptual Motor Training
❒ OT to provide perceptual motor training
❒ _____
_____

Fine Motor Coordination
❒ OT to provide fine motor/dexterity activities
❒ _____
❒ _____

Neurodevelopmental Treatment
❒ OT to provide neurodevelopmental treatment
_____
_____

Sensory Treatment
❒ OT to provide sensory integration training
_____
_____

Orthotics/Splinting
❒ Provide training in donning/doffing of orthosis/splint
❒ Monitor effectiveness of orthosis/splint and joint alignment
❒ _____
_____
_____

Adaptive Equipment
❒ OT to provide
_____
_____
_____

Other
OT to:
❒ Establish home exercise program
❒ _____
_____

GOALS: Rehab Potential: ❒ Good ❒ Fair

1. Patient will demonstrate increased muscle strength of _____ (muscle(s) to _____ (grade) within _____ weeks.
2. Patient will demonstrate increased ROM of _____ (joint(s) to _____ (ROM) within _____ weeks.
3. Patient will demonstrate increased fine motor coordination of _____ to _____ within _____ weeks.
4. Patient will demonstrate improvement of _____ transfers to _____ (level of assist) within _____ weeks.
5. Patient/Caregiver will demonstrate appropriate use of _____ (assistive device/DME) within _____ days/weeks.
6. Patient will demonstrate improvement in the following ADLs to the stated level of assistance within the stated weeks:
   _____ _____ _____ weeks
   _____ _____ _____ weeks
   _____ _____ _____ weeks
7. Patient/Caregiver will be independent in home exercise program within _____ weeks.
8. Patient/Caregiver will verbalize understanding of discharge plan within _____ days/weeks.
9. Other: _____
   _____

Therapist's Signature: _____ Date: ____/____/____

Physician's Signature: _____ Date: ____/____/____