MILLENIUM HOME HEALTH CARE, INC.

REQUEST FOR ADDITIONAL OCCUPATIONAL THERAPY VISITS

RETURN FORM TO: Pamela Brunner @ Fax: 484-908-6620 Phone: 610-543-4126

Client Name: _____ Therapist: _____

# of Visits Requested: _____ Dates: _____

OCCUPATIONAL THERAPY REQUEST

◯ADL Training ◯Home Exercise program ◯Home Safety/Energy conservation

Teach/Assist with ADLs: ◯Cooking ◯Dressing ◯Bathing ◯Groom ◯Feeding/Writing/Reading
◯Other: _____

_____

Progress Towards Goals: ◯ None ◯ Plateau ◯ Minimal ◯ Moderate ◯ Significant

Functional Status: (REQUIRED for any OT request for additional visits)

	Dependent	Max Assist	Mod Assist	Min Assist	Contact Guard	Supervision	Indep
Ambulation Distance							
Asst. Device							
# stairs_____							
TRANSFERS							
Bed Mobility							
Sit to Stand							
Bed to Chair							
Toilet							
Shower							
ADLs – UE							
ADLs - LE							

Note: Please be sure to write in the distance that pt is ambulating at the time of your request.

Strength: _____ Endurance: _____ Balance: _____

Goals:

Date: _____