**Occupational Therapy**

**Re-Evaluation \_\_\_ Progress Note\_\_\_ Discharge\_\_\_ (check what is included)**

Must provide contact information:

|  |  |
| --- | --- |
| **YOUR FACILITY NAME/LOCATION:** | Therapy Lab of OC/18837 Brookhurst Street Suite # 109 Fountain Valley, Ca 92708 |
| **TREATING THERAPIST NAME:** | Meg Menchavez, COTA |
| **PHONE NUMBER:** | 714-861-9595 |
| **EMAIL for contact :** | kristin@therapylabofoc.com  |

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| **Patient Name:** | xx |
| **Kaiser Medical Record Number:**  | YY |
| **Birth date / Age:** | xx |
| **Date of report:** | xx |
| **Authorization period:** | YY |
| **First and last dates of service:** | xx |
| **Diagnosis** (ICD-10 Code and description—these are provided to you upon referral. Do not add new ones without prior approval):* Autism spectrum disorder; ICD10: F84.0
 |

This is cumulative chart to be carried over from report to report

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| **O.T .** | Initial Assmt | 6 MoPr RPT | Year 1Re-Eval | 6 MoPr Rpt | Year 2Re-Eval | 6 MoPr Rpt | Year 3Re-Eval | 6 MoPr Rpt | Year 4Re-Eval | 6 MoPr Rpt |
| **DATE:**  |  |  |  |  |  |  |  |  |  |  |
| **Complete below for each authorization period**  |
| # of authorized appts |  |  |  |  |  |  |  |  |  |  |
| # of appts attended |  |  |  |  |  |  |  |  |  |  |
| Therapist Cancellations |  |  |  |  |  |  |  |  |  |  |
| Family Cancellations |  |  |  |  |  |  |  |  |  |  |
| Frequency per week/month  |  |  |  |  |  |  |  |  |  |  |
| Total #goals |  |  |  |  |  |  |  |  |  |  |
| Total # of goals met  |  |  |  |  |  |  |  |  |  |  |

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| **Caregiver concerns related to OT and goals for therapeutic intervention:*** Parents are concerned with feeding and ADLs.
 |
| **Name(s) of treating occupational therapists and /or assistants:** | Meg Menchavez, COTA and Raquel Morrill, OTD, OTR/L |
| **Techniques and skilled interventions:** | Fine motor and sensory integration. Movement and sensory breaks. SOS Feeding therapy. ADL.  |

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| **ASSESSMENT** |
|  | *Interpretation of findings and standardized test results: Include sensory and motor test results* ***HERE****. ADL and Feeding (if already part of care plan) test results to be reported in table* ***below****.* * Parent Interview/History:
* Clinical observations:
* Standardized testing (Sensory, Motor, Other):
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| **STANDARDIZED RE-EVALUATION RESULTS OF FUNCTIONAL SKILLS***If testing data goes beyond 4 years, please retitle the columns for years as needed. Always keep the initial assessment column* |
|  | **Initial Assmt****Date:** | **Year 1****Date:** | **Year 2****Date:** | **Year 3****Date:** | **Year 4****Date:** |
| Feeding description(N/A if not addressing feeding) |  |  |  |  |  |
| Current food list (N/A if not addressing feeding) |  |  |  |  |  |
| ADLS: | Test Used: | Test Used: | Test Used: | Test Used: | Test Used: |
| **Raw score** |  |  |  |  |  |
| **Standard Score** |  |  |  |  |  |
| **Scale Score** |  |  |  |  |  |
| **Percentile****Not percentage of delay** |  |  |  |  |  |
| **Comments:** |  |  |  |  |  |

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| *Fine motor: Are there fine motor impairments impacting developmentally appropriate self-help routines?*  |
| *Gross motor: Are there gross motor, balance, vestibular, visual motor, or sensory impairments impacting developmentally appropriate self-help routines?* |
| *Self-help skills: Are ADL’s age appropriate? (Describe why or why not)* |
| *Progress/lack of progress with OT and why (behavior, lack of family participation, etc):* |

**CURRENT GOALS**: *LT goals should be related to self-help and function. They must be measurable and include measurement and time frame. (Please avoid writing, coloring, and scissor cutting goals. These activities may be used in treatment as building blocks but are not the end goal. (Instead focus on grasp with feeding utensils and bilateral tasks related to feeding, dressing, etc.)*

 ***Goal Status M: Met PR/CG: Progressing/Continue Goal NM/DG: Not Met/Discontinue Goal***

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| *GOALS:* ***Goals must be SMART (specific, measurable, achievable, realistic and timely).*** | ***Goal Status*** |
| *1.* Baseline:Current status:Timeframe: 6 months  |  |
| *2.* Baseline: Current status:Timeframe: 6 months  |  |
| *3.* Baseline: Current status:Timeframe: 6 months  |  |
| *4.* Baseline: Current status:Timeframe: 6 months  |  |
|  |  |

***Baseline= Status at time goal was originally written***

***Current Status=Include rationale if lack of progress***

***NEW GOALS: Goals must be SMART (specific, measurable, achievable, realistic and timely).***

*Please list previous goals to be continued- Goal #’s : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**R: Revised NG: New Goal**

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| *NEW GOALS* | ***Goal Status*** |
| *1.* Baseline:Timeframe: 6 months  |  |
| *2.* Baseline: Timeframe: 6 months  |  |
| *3.* Baseline: Timeframe: 6 months  |  |
| *4.* Baseline: Timeframe: 6 months  |  |
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| ***HOME ACTIVITY PROGRAM:*** |
| S*pecific home program activities:* |
| *Family participation (who, when, how often):** The parent will participate in facilitating the home program for a minimum of 3 times per week.
 |
| *Is family able to demonstrate home program?: Yes, the family is able to demonstrate the home program without any problems.*  |

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| *Check One* | ***RECOMMENDATIONS*** |
|  | ***Continue Therapy at the established frequency of: x/week . /months****Showing measurable gains from therapy, as demonstrated by:* |
|  | ***Reduce frequency of therapy to: x/week for /months*** *Rationale:*  |
|  | ***Increase frequency or type of therapy to: : x/week .*** *Rationale:*  |
|  | ***Discharge: see below*** |

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| *Check* ***One*** | ***DISCHARGE PLANNING*** |
|  | ***Provided continued functional progress, it is anticipated that skilled occupational therapy services may be warranted for up to \_\_\_12\_\_\_\_\_months ( 6 months, 12 months, 18 months, 24 months)  from this reporting period, pending progress at that time.***  |
|  | ***Discharge –has reached age appropriate function.*** |
|  | ***Discharge – has reached functional level of performance*** |
|  | ***Discharge-progress with therapy has plateaued*** |
|  | ***Discharge – not able to participate in skilled therapy due to lack of attention/behavior.*** |
|  | ***Discharge :***  |

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| ***OTHER RECOMMENDATIONS*** *(Include any information regarding requests for specialist consultation. (Family will need to make these requests with their PCP)** N/A
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| Raquel Morrill, OTD. OTR/L | *Raquel Morrill, OTD, OTR/L* |
| Therapist Name (include credentials) | Therapist signature |
| Raquelrios92@gmail.com | 714-861-9595 |
| Therapist e-mail | Therapist phone number |