# Occupational Therapy Documentation Cheat Sheet

#### Patient Information:

- · Full name, date of birth, contact information
- Referring physician or healthcare provider
- Insurance information

#### Occupational Profile:

- · Client's occupations, roles, and routines
- Client's goals and priorities
- Client's strengths and limitations

#### Assessment Section:

- Objective measurements (e.g., ROM, strength)
- Subjective observations (e.g., pain level, client's response)

## Intervention:

- Specific interventions used during therapy sessions
- Therapeutic activities and exercises
- Home exercise program recommendations

#### Progress Notes:

- Client's progress towards goals
- Any changes in treatment plans
- Client's response to interventions

#### Documentation Tips:

- Be concise and relevant, avoid unnecessary details
- Use SOAP note format (Subjective, Objective, Assessment, Plan)
- · Sign and date each entry for accountability

## Legal and Compliance:

- Ensure documentation meets regulatory standards
- Protect client confidentiality at all times

#### Additional Resources:

- AOTA's Guidelines for Occupational Therapy Documentation
- Sample documentation templates for reference

# **Guidelines For Occupational Therapy Services In Home Health**

**Lei Huang** 

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