

Guidelines for Documentation of Occupational Therapy

Documentation of occupational therapy services is necessary whenever professional services are provided to a client. Occupational therapists and occupational therapy assistants¹ determine the appropriate type of documentation structure and then record the services provided within their scope of practice. This document, based on the *Occupational Therapy Practice Framework: Domain and Process* (American Occupational Therapy Association [AOTA], 2008), describes the components and purpose of professional documentation used in occupational therapy.

AOTA's *Standards of Practice for Occupational Therapy* (2010) states that an occupational therapy practitioner² documents the occupational therapy services and "abides by the time frames, format, and standards established by the practice settings, government agencies, external accreditation programs, payers, and AOTA documents" (p. S108). These requirements apply to both electronic and written forms of documentation. Documentation should reflect the nature of services provided and the clinical reasoning of the occupational therapy practitioner, and it should provide enough information to ensure that services are delivered in a safe and effective manner. Documentation should describe the depth and breadth of services provided to meet the complexity of individual client³ needs. The client's diagnosis or prognosis should not be used as the sole rationale for occupational therapy services.

The purpose of documentation is to

- Communicate information about the client from the occupational therapy perspective;
- Articulate the rationale for provision of occupational therapy services and the relationship of those services to client outcomes, reflecting the occupational therapy practitioner's clinical reasoning and professional judgment; and
- Create a chronological record of client status, occupational therapy services provided to the client, client response to occupational therapy intervention, and client outcomes.

Types of Documentation

Table 1 outlines common types of documentation reports. Reports may be named differently or combined and reorganized to meet the specific needs of the setting. Occupational therapy documentation should always record the practitioner's activity in the areas of screening, evaluation, intervention, and outcomes (AOTA, 2008) in accordance with payer, facility, and state and federal guidelines.

¹*Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2009).

²When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).

³In this document, *client* may refer to an individual, organization, or population.

Table 1. Common Types of Occupational Therapy Documentation Reports	
Process Areas	Type of Report
I. Screening	A. Screening Report
II. Evaluation	A. Evaluation Report B. Reevaluation Report
III. Intervention	A. Intervention Plan B. Contact report note or communiqué C. Progress Report/Note D. Transition Plan
IV. Outcomes	A. Discharge/Discontinuation Report

Content of Reports

I. Screening

- A. Documents referral source, reason for occupational therapy screening, and need for occupational therapy evaluation and service.
 - 1. Phone referrals should be documented in accordance with payer, facility, and state and federal guidelines and include
 - a. Names of individuals spoken with,
 - b. Purpose of screening,
 - c. Date of request,
 - d. Number of contact for referral source, and
 - e. Description of client’s prior level of occupational performance.
- B. Consists of an initial brief assessment to determine client’s need for an occupational therapy evaluation or for referral to another service if not appropriate for occupational therapy services.
- C. Suggested content:
 - 1. *Client information*—Name/agency; date of birth; gender; health status; and applicable medical/educational/developmental diagnoses, precautions, and contraindications
 - 2. *Referral information*—Date and source of referral, services requested, reason for referral, funding source, and anticipated length of service
 - 3. *Brief occupational profile*—Client’s reason for seeking occupational therapy services, current areas of occupation that are successful and problematic, contexts and environments that support and hinder occupations, medical/educational/work

- history, occupational history (e.g., patterns of living, interest, values), client's priorities, and targeted goals
4. *Assessments used and results*—Types of assessments used and results (e.g., interviews, record reviews, observations)
 5. *Recommendation*—Professional judgments regarding appropriateness of need for complete occupational therapy evaluation.

II. Evaluation

A. Evaluation Report

1. Documents referral source and data gathered through the evaluation process in accordance with payer, facility, state, and/or federal guidelines. Includes
 - a. Analysis of occupational performance and identification of factors that support and hinder performance and participation and
 - b. Identification of specific areas of occupation and occupational performance to be addressed, interventions, and expected outcomes.
2. Suggested content:
 - a. *Client information*—Name; date of birth; gender; health status; medical history; and applicable medical/educational/developmental diagnoses, precautions, and contraindications
 - b. *Referral information*—Date and source of referral, services requested, reason for referral, funding source, and anticipated length of service
 - c. *Occupational profile*—Client's reason for seeking occupational therapy services, current areas of occupation that are successful and problematic, contexts and environments that support or hinder occupations, medical/educational/work history, occupational history (e.g., patterns of living, interest, values), client's priorities, and targeted outcomes
 - d. *Assessments used and results*—Types of assessments used and results (e.g., interviews, record reviews, observations, standardized and/or nonstandardized assessments)
 - e. *Analysis of occupational performance*—Description of and judgment about performance skills, performance patterns, contexts and environments, activity demands, outcomes from standardized measures and/or nonstandardized assessments⁴, and client factors that will be targeted for intervention and outcomes

⁴ Nonstandardized assessment tools are considered a valid form of information gathering that allows for flexibility and individualization when measuring outcomes related to the status of an individual or group through an intrapersonal comparison. Although not uniform in administration or scoring or possessing full and complete psychometric data, nonstandardized assessment tools possess strong internal validity and represents an evidence-based approach to occupational therapy practice (Hinojosa, J., Kramer, P. & Christ, P. , 2010). **Nonstandardized**

expected

- f. *Summary and analysis*—Interpretation and summary of data as related to occupational profile and referring concern
- g. *Recommendation*—Judgment regarding appropriateness of occupational therapy services or other services.

Note: The intervention plan, including intervention goals addressing anticipated outcomes, objectives, and frequency of therapy, is described in the “Intervention Plan” section that follows.

B. Reevaluation Report

1. Documents the results of the reevaluation process. Frequency of reevaluation depends on the needs of the setting, the progress of the client, and client changes.
2. Suggested content:
 - a. *Client information*—Name; date of birth; gender; and applicable medical/educational/developmental diagnoses, precautions, and contraindications
 - b. *Occupational profile*—Updates on current areas of occupation that are successful and problematic, contexts and environments that support or hinder occupations, summary of any new medical/educational/work information, and updates or changes to client’s priorities and targeted outcomes
 - c. *Reevaluation results*—Focus of reevaluation, specific types of outcome measures from standardized and/or nonstandardized assessments used, and client’s performance and subjective responses.
 - d. *Analysis of occupational performance*—Description of and judgment about performance skills, performance patterns, contexts and environments, activity demands, outcomes from standardized measures and/or nonstandardized assessments, and client factors that will be targeted for intervention and outcomes expected
 - e. *Summary and analysis*—Interpretation and summary of data as related to referring concern and comparison of results with previous evaluation results
 - f. *Recommendations*—Changes to occupational therapy services, revision or continuation of interventions, goals and objectives, frequency of occupational therapy services, and recommendation for referral to other professionals or agencies as applicable.

tools should be selected based on best available evidence and the clinical reasoning of the practitioner.

III. Intervention

A. Intervention Plan

1. Documents the goals, intervention approaches, and types of interventions to be used to achieve the client's identified targeted outcomes and is based on results of evaluation or reevaluation processes. Includes recommendations or referrals to other professionals and agencies in adherence with each payer source documentation requirements (e.g., pain levels, time spent on each modality).
2. Suggested content:
 - a. *Client information*—Name; date of birth; gender; precautions; and contraindications
 - b. *Intervention goals*—Measurable and meaningful occupation-based long-term and short-term objective goals directly related to the client's ability and need to engage in desired occupations
 - c. *Intervention approaches and types of interventions to be used*—Intervention approaches that include create/promote, establish/restore, maintain, modify, and/or prevent; types of interventions that include consultation, education process, advocacy, and/or the therapeutic use of occupations or activities.
 - d. *Service delivery mechanisms*—Service provider, service location, and frequency and duration of services
 - e. *Plan for discharge*—Discontinuation criteria, discharge setting (e.g., skilled nursing facility, home, community, classroom) and follow-up care
 - f. *Outcome measures*—Tools that assess occupational performance, adaptation, role competence, improved health and wellness, , improved quality of life, self-advocacy, and occupational justice. Standardized and/or nonstandardized assessments used at evaluation should be readministered periodically to monitor measurable progress and report functional outcomes as required by client's payer source and/or facility requirements.
 - g. *Professionals responsible and date of plan*—Names and positions of persons overseeing plan, date plan was developed, and date when plan was modified or reviewed.

B. Service Contacts

1. Documents contacts between the client and the occupational therapy practitioner. Records the types of interventions used and client's response, which can include telephone contacts, interventions, and meetings with others.
2. Suggested content:
 - a. *Client information*—Name; date of birth; gender; and diagnosis, precautions, and contraindications
 - b. *Therapy log*—Date, type of contact, names/positions of persons involved, summary or significant information communicated during contacts, client

attendance and participation in intervention, reason service is missed, types of interventions used, client's response, environmental or task modification, assistive or adaptive devices used or fabricated, statement of any training education or consultation provided, and the client's present level of performance. Documentation of services provided should reflect the complexity of the client and the professional clinical reasoning and expertise of an occupational therapy practitioner required to provide an effective outcome in occupational performance. The client's diagnosis or prognosis should not be the sole rationale for the skilled interventions provided. Measures used to assess outcomes should be repeated in accordance with payer and facility requirements and documented to demonstrate measurable functional progress of the client.

c. *Intervention/procedure coding* (i.e., *CPT*TM),⁵ if applicable.

C. Progress Report/Note

1. Summarizes intervention process and documents client's progress toward achievement of goals. Includes new data collected; modifications of treatment plan; and statement of need for continuation, discontinuation, or referral.
2. Suggested content:
 - a. *Client information*—Name; date of birth; gender; and diagnosis, precautions, and contraindications
 - b. *Summary of services provided*—Brief statement of frequency of services and length of time services have been provided; techniques and strategies used; measureable progress or lack thereof using age-appropriate current functional standardized and/or nonstandardized outcome measures; environmental or task modifications provided; adaptive equipment or orthotics provided; medical, educational, or other pertinent client updates; client's response to occupational therapy services; and programs or training provided to the client or caregivers
 - c. *Current client performance*—Client's progress toward the goals and client's performance in areas of occupations
 - d. *Plan or recommendations*—Recommendations and rationale as well as client's input to changes or continuation of plan.

D. Transition Plan

1. Documents the formal transition plan and is written when client is transitioning from one service setting to another within a service delivery system.
2. Suggested content:
 - a. *Client information*—Name; date of birth; gender; and diagnosis, precautions, and contraindications
 - b. *Client's current status*—Client's current performance in occupations

⁵ *CPT* is a trademark of the American Medical Association (AMA). *CPT* five-digit codes, nomenclature, and other data are copyright © 2011 by the AMA. All rights reserved.

- c. *Transition plan*—Name of current service setting and name of setting to which client will transition, reason for transition, time frame in which transition will occur, and outline of activities to be carried out during the transition plan
- d. *Recommendations*—Recommendations and rationale for occupational therapy services, modifications or accommodations needed, and assistive technology and environmental modifications needed.

IV. Outcomes

A. Discharge Report—Summary of Occupational Therapy Services and Outcomes

1. Summarizes the changes in client’s ability to engage in occupations between the initial evaluation and discontinuation of services and makes recommendations as applicable
2. Suggested content:
 - a. *Client information*—Name; date of birth; gender; and diagnosis, precautions, and contraindications
 - b. *Summary of intervention process*—Date of initial and final service; frequency, number of sessions, and summary of interventions used; summary of progress toward goals; and occupational therapy outcomes—initial client status and ending status regarding engagement in occupations, client’s assessment of efficacy of occupational therapy services, and comparison of pre- and postintervention standardized and/or nonstandardized outcome measures used
 - c. *Recommendations*—Recommendations pertaining to the client’s future needs; specific follow-up plans, if applicable; and referrals to other professionals and agencies, if applicable.

Each occupational therapy client has a client record maintained as a permanent file. The record is maintained in a professional and legal fashion (i.e., organized, legible, concise, clear, accurate, complete, current, grammatically correct, objective). Box 1 lists the fundamental elements of documentation.

Box 1. Fundamentals of Documentation

- Client’s full name and case number (if applicable) on each page of documentation
- Date
- Identification of type of documentation (e.g., evaluation report, progress report/note)
- Occupational therapy practitioner’s signature with a minimum of first name or initial, last name, and professional designation

- When applicable, signature of the recorder directly after the documentation entry. If additional information is needed, a signed addendum must be added to the record.
- Co-signature of an occupational therapist or occupational therapy assistant on student documentation, as required by payer policy, governing laws and regulations, and/or employer
- Compliance with all laws, regulations, payer, and employer requirements
- Acceptable terminology defined within the boundaries of setting
- Abbreviations usage as acceptable within the boundaries of setting
- All errors noted and signed
- Adherence to professional standards of technology, when used to document occupational therapy services with electronic claims or records.
- Disposal of records (electronic and traditionally written) within law or agency requirements
- Compliance with confidentiality standards
- Compliance with agency or legal requirements of storage of records
- Documentation should reflect professional clinical reasoning and expertise of an occupational therapy practitioner and the nature of occupational therapy services delivered in a safe and effective manner. The client's diagnosis or prognosis should not be the sole rationale for occupational therapy services.

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