Occupational Therapy Care Plan

Date: **Student:** **DOB:** **School:**

Student's Physician: **Student's Diagnosis (ICD10):** **Physician NPI:** **Service Level:** **Date of Medical Referral:**

This student is currently eligible for occupational therapy services as indicated on his/her .

Date to begin: **Duration of Plan:**

Goals/Objectives:

Student Participation Areas to be Addressed/Current Functioning	Does Not Limit Participation	Limits Participation	Not Tested
1. Upper extremities			
a. Range of motion			
b. Muscle tone			
c. Muscle strength			
2. Head control			
3. Trunk control /Posture			
4. Bilateral coordination			
5. Handwriting skills			
6. Fine motor skills			
7. Visual /motor perceptual skills			
8. Oral motor skills, cafeteria, feeding			
9 Self-care skills, bathroom management			
10. Sensory motor processing			
11. Other:			

Possible Interventions: (CPT codes)

Skilled Intervention: Individual Therapy Group Therapy Both

Fine Motor Handwriting Visual Motor Sensorimotor

Self-Help/ Adaptive Oral Motor/Feeding Other

Consult/Training: (refer to plan located in student's folder)

Classroom Strategies/Team Consultation
Feeding Plan
Environmental Modification/Adaptation
Adaptive Equipment
Staff Training

Plan for Exit from Services:

Occupational Therapist Signature/NPI number Date