Documentation is necessary whenever professional services are provided to a client. Occupational therapists and occupational therapy assistants under the supervision of an occupational therapist determine the appropriate type of documentation and document 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], 2002), describes the components and the purpose of professional documentation used in occupational therapy. AOTA’s *Standards of Practice for Occupational Therapy* (1998) state: “An occupational therapy practitioner documents the occupational therapy services provided within the time frames, format, and standards established by the practice settings, agencies, external accreditation programs, and payers.” In this document, client may refer to an individual, family/caregivers, group, or population.

The purpose of documentation is to
- Articulate the rationale for provision of occupational therapy services and the relationship of this service to the client’s outcomes
- Reflect the therapist’s clinical reasoning and professional judgment
- Communicate information about the client from the occupational therapy perspective
- Create a chronological record of client status, occupational therapy services provided to the client, and client outcomes.

Types of Documentation

The following chart outlines common types of reports. Depending on the service delivery and setting, reports may be named differently or combined and reorganized to meet the specific needs of the setting. Occupational therapy documentation should always record the professional’s activity in the areas of evaluation, intervention, and outcomes (AOTA, 2002).

<table>
<thead>
<tr>
<th>Process Areas</th>
<th>Type of Report</th>
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<td>I. Evaluation</td>
<td>A. Evaluation or Screening Report</td>
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<td>II. Intervention</td>
<td>A. Intervention Plan</td>
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<td>B. Occupational Therapy Service Contacts</td>
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<td>III. Outcomes</td>
<td>A. Discharge/Discontinuation Report</td>
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</tbody>
</table>

Content of Reports

I. Evaluation

A. Evaluation or Screening Report

1. Documents the referral source and data gathered through the evaluation process. Includes:
   a. Description of the client’s occupational profile
   b. Analysis of occupational performance and identification of factors that hinder and support performance in areas of occupation
   c. Delineation of specific areas of occupation that will be targeted for intervention and outcomes expected

2. An abbreviated evaluation process (e.g., screening) documents only limited areas of occupation applicable to the client and to the situation.

3. Suggested content with examples:
   a. *Client information*—name/agency, date of birth, gender, 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 areas that are problematic, contexts 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, and standardized or nonstandardized assessments), description of the client factors, contextual aspects or features of the activities that facilitate or inhibit performance, and confidence in test results
   e. *Summary and analysis*—interpretation and summary of data as it is related to occupational profile and referring concern
   f. *Recommendation*—judgment regarding appropriateness of occupational therapy services or other services
Note: Intervention goals addressing anticipated outcomes, objectives, and frequency of therapy are listed on the Intervention Plan.

B. Reevaluation Report
1. Documents the results of the reevaluation process. Frequency of reevaluation depends upon the needs of the setting and the progress of the client.
2. Suggested content with examples:
   a. Client information—name/agency, date of birth, gender, applicable medical/educational/developmental diagnoses, precautions, and contraindications
   b. Occupational profile—updates on current areas of occupation that are successful and that are problematic, contexts 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 assessments used, and client’s performance and subjective responses
   d. Summary and analysis—interpretation and summary of data as related to referring concern, and comparison of results with previous evaluation results
   e. Recommendations—changes to occupational therapy services, revision or continuation of goals and objectives, frequency of occupational therapy services, and recommendation for referral to other professionals or agencies where applicable

II. 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 based on results of evaluation or reevaluation processes. Includes recommendations or referrals to other professionals and agencies.
2. Suggested content with examples:
   a. Client information—name/agency, date of birth, gender, precautions, and contraindications
   b. Intervention goals—measurable goals and short-term objectives directly related to the client’s ability 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 prevent; types of interventions that include consultation process, education process, therapeutic use of activities to enhance occupation, and therapeutic use of self
   d. Service delivery mechanisms—service provider, service location, and frequency and duration of services
   e. Plan for discharge—discontinuation criteria, location of discharge, and follow-up care
   f. Outcome measures—outcomes that include improved occupational performance, client satisfaction, role competence, improved health and wellness, prevention of further difficulties, and improved quality of life
   g. Professionals responsible and date of plan—names and positions of persons overseeing intervention plan, date plan was developed, and date when plan was modified or reviewed

B. Occupational Therapy Service Contacts
1. Documents contacts between the client and the occupational therapist or the occupational therapy assistant. Records the types of interventions used and client’s response. Includes telephone contacts, interventions, and meetings with others.
2. Suggested content with examples:
   a. Client information—name/agency, date of birth, gender, 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 persons present

C. Progress Report
1. Summarizes intervention process and documents client’s progress toward goals achievement. Includes new data collected; modifications of treatment plan; and statement of need for continuation, discontinuation, or referral.
2. Suggested content with examples:
   a. Client information—name/agency, date of birth, gender, 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; environmental or task modifications pro-
vided; 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 with examples:
   a. Client information—name/agency, date of birth, gender, diagnosis, precautions, and contraindications
   b. Client’s current status—client’s current performance in occupations
   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

III. Outcomes

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

1. Summarize the changes in client’s ability to engage in occupations between the initial evaluation and discontinuation of services and make recommendations as applicable

2. Suggested content with examples:
   a. Client information—name/agency, date of birth, gender, diagnosis, precautions, and contraindications
   b. Summary of intervention process—date of initial and final service; frequency, number of sessions, 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

   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

APPENDIX A
Fundamental Elements of Documentation

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, and objective). The following elements are present in all documentation:

1. Client’s full name and case number (if applicable) on each page of documentation.
2. Date and type of occupational therapy contact.
3. Identification of type of documentation, agency, and department name.
4. Occupational therapist’s or occupational therapy assistant’s signature with a minimum of first name or initial, last name, and professional designation.
5. When applicable on notes or reports, signature of the recorder directly at the end of the note without space left between the body of the note and the signature.
6. Countersignature by an occupational therapist on documentation written by students and occupational therapy assistants when required by law or the facility.
7. Acceptable terminology defined within the boundaries of setting.
8. Abbreviations usage as acceptable within the boundaries of setting.
9. When no facility requirements are listed, errors corrected by drawing a single line through an error and by initialing the correction (liquid correction fluid and erasures are not acceptable).
10. Adherence to professional standards of technology, when used to document occupational therapy services.
11. Disposal of records within law or agency requirements.
12. Compliance with confidentiality standards.
13. Compliance with agency or legal requirements of storage of records.

References


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