McLAREN FLINT
Flint, Michigan 48532

OCCUPATIONAL THERAPY PROGRESS REPORT

Date: _____

REFERRING PHYSICIAN: _____ Phone: _____ Fax: _____

PRIMARY PHYSICIAN: _____ Phone: _____ Fax: _____

PATIENT: _____ Date of Birth: _____

DIAGNOSIS: _____

The patient attended therapy _____ Visits _____ No Shows _____ Cancellations with treatment consisting of:

1. _____ 3. _____

2. _____ 4. _____

OBJECTIVE PROGRESS:	IMPROVEMENT	REGRESSED	NO CHANGE	N/A	COMMENTS:
ROM	☐	☐	☐	☐	
STRENGTH	☐	☐	☐	☐	
PAIN	☐	☐	☐	☐	
ADL	☐	☐	☐	☐	
GAIT	☐	☐	☐	☐	

ASSESSMENT/CLINICAL IMPRESSION

_____

_____

_____

_____

_____

_____

_____

_____

PLAN/GOALS:

_____

_____

_____

Therapist: _____ Facility: _____

Telephone: _____ Fax Number: _____

OCCUPATIONAL THERAPY PROGRESS REPORT

MHCC-2855-B (1/15)

450b

PT.

MR.#/RM.

DR.