Occupational Therapy Home Visit Report

Client Details

Name

Date of Birth

Address

Phone

Report Date

Reason for Visit

Presenting Issues / Medical History

Assessments Conducted

Home Environment Overview

Living Situation

Support Network

Physical Environment (Access, Layout, Safety)

Functional Abilities

Mobility / Transfers

Activities of Daily Living (ADLs)

Communication / Cognition

Identified Risks

Recommendations

Equipment / Assistive Devices

Home Modifications

Support Services

Other Recommendations

Summary / Plan

Occupational Therapist Name

Signature

Date