**Stable Life Concepts**

**Client Intake Packet**

**Addendum:**

**OT Services**

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**What is Occupational Therapy?**

In its simplest terms, occupational therapists and occupational therapy assistants help people across the lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping children with disabilities to participate fully in school and social situations, facilitating the activities of feeding, eating, and swallowing safely, holistically addressing the physical, psychosocial, and cultural factors associated with feeding, eating, and swallowing, helping people recovering from injury to regain skills, and providing supports for older adults experiencing physical and cognitive changes. Occupational therapy services typically include:

* an individualized evaluation, during which the client/family and occupational therapist determine the person’s goals,
* customized intervention to improve the person’s ability to perform daily activities and reach the goals, and
* an outcomes evaluation to ensure that the goals are being met and/or make changes to the intervention plan.

Occupational therapy services may include comprehensive evaluations of the client’s home and other environments (e.g., workplace, school), recommendations for adaptive equipment and training in its use, and guidance and education for family members and caregivers. Occupational therapy practitioners have a holistic perspective, in which the focus is on adapting the environment to fit the person, and the person is an integral part of the therapy team.

**What is Required to Start OT Services?**

1. Completed Intake Packet: any other evaluations or reports would be helpful
2. Intake Interview
3. If insurance is involved then pre-authorization is required prior to any evaluation, therapy or other services being provided
4. Assessments completed by Stable Life Concepts and parents
5. Meeting with Clinical Supervisor to discuss treatment goals and program plan
6. Arrangement of therapy schedule

**Insurance Rates of Service**

* Assessment- $500
* OT- $125 per hour
* Copays per policy

**Required Documentation**

* Qualifying Diagnosis
* Primary Care Manager Referral
* Authorization (insurance)

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| **OT Initial Intake Form** | | |
| Client Name: | |  |
| DOB: | IEP: Y or N |
| Current School: | |
| **Medical** | |
| Referring Provider: | | |
| Diagnosis: | | |
| **Other Services (please list any other services your child is enrolled in):** | | |
|  | | |

Informed Consent for Assessment and Services

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as a parent or guardian, give my consent for Stable Life Concepts to provide assessment and occupational services to my child, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**, in accordance with the ethical guidelines proposed by The National Board for Certification in Occupational Therapy (NBCOT). I also understand that I may withdraw my consent and terminate treatment at any time and for any reason.

I understand that any information provided in this intake as well as any information obtained at any point during the interview process or course of treatment, is kept strictly confidential in accordance with HIPAA regulation guidelines and the law.

I understand that Occupational Therapists are bound to strict ethical guidelines of practice and that any issues of concern that may arise throughout the treatment process that are out of the OT’s area of experience may result in referrals to a more appropriate agency or individual.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STOP**

STOP: The rest of this form will be filled out in the intake with the Occupational Therapist. Please be sure to bring the entire form with you to your scheduled appointment.

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| --- | --- |
| **Parent/Guardian Behavioral Observances:** | |
| **Strength**  **Endurance** |  |
| **Tone** | Spasticity Hypertonic WNL Hypotonic Dystonic |
| **Cognition** | Planning/Organization/Execution:  Error Recognition:  Processing Speed:  Memory:  Attention:  Problem solving:  Understanding time and his/her schedule: |
| **Sensory** | Proprioception:  Hugs:  Tactile:  Face/handwashing:  Tags on clothing:  Textures that bother:  Vestibular:  Swing: Trampoline: Car:  Auditory:  Noises that bother:  Visual:  Modulation/Sleep: |
| **ADLs** | Dressing:  T-Shirt Pants Jacket Zipper Buttons Socks Shoes  Grooming:  Hair Brushing: Toothbrushing:  Hygiene: Handwashing:  Toileting:  Bathing: Towel Drying:  Feeding:  Spoon Fork Knife Lids/Containers Pouring Liquids Straws  Nutritional Requirements:  Reg Diet for Age Mechanical Soft G-Button Enteral Feeding Pump    Other: |
| **FM/VMI** | L / R Hand Dominance: Grasp:  VMI:  Motor Planning:  Scribing/Writing: O -- | +  Bilat Coordination: Crossing Midline:  Letters/Numbers:  Coordination skills / clumsiness / frequently dropping items: |
| **Visual Perception** | Size: Reversals:  Orientation: Spacing:  Sentences: Speed: |
| **Other** | Counting money (coins, dollar bills):  Being in a crowd, going to a restaurant, going to an unfamiliar place:  Eat Table Foods/being a picky eater:  Understanding time and his/her schedule: |

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| **Top Three Concerns:** |
| 1. |
| 2. |
| 3. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Desired Days/Times (fill in times below days):** | | | | |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
|  |  |  |  |  |
|  |  |  |  |  |

Other: