

<b>Sample Documentation of Occupational Therapy Therapy Services</b>					Diagnosis Code	
Student:	DOB:	Medicaid#:	<input type="checkbox"/> 343.9	<input type="checkbox"/> 343.0	<input type="checkbox"/> 854.00	
Place of Service:	School (03) <input type="checkbox"/> Home (12) <input type="checkbox"/> Other (99) <input type="checkbox"/>		<input type="checkbox"/> 758.0	<input type="checkbox"/> 369.00	<input type="checkbox"/> Other	
District:	School Name:		<input type="checkbox"/> 299.00	<input type="checkbox"/> 317		
Therapist Name/Title:						

Procedure Code	Objectives	Activities/Consultation	Results	Progress	Plan	Narrative (Individualized description of activity and results).
Date: _____/_____/_____  <input type="checkbox"/> 97003 -GO <input type="checkbox"/> 97530 -GO <input type="checkbox"/> 97150 -GO <input type="checkbox"/> L _____  Minutes: _____  Units: _____  Initials: _____	<u>Obj. #</u>	<input type="checkbox"/> ADL / Self Help <input type="checkbox"/> Positioning <input type="checkbox"/> Fine Motor Activities <input type="checkbox"/> Sensory Activities <input type="checkbox"/> Visual Motor Activity <input type="checkbox"/> Visual- Perceptual <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Academic Support <input type="checkbox"/> Handwriting Program <input type="checkbox"/> Other _____	___ % correct ___ of ___ correct ___ Not assessed Other: _____ _____ _____ _____	___ Mastered ___ Progress ___ No change ___ Regression Other: _____ _____ _____	___ Continue objective ___ Objective met ___ Initiate new objective ___ Consult ___ Discontinue _____ _____	
Date: _____/_____/_____  <input type="checkbox"/> 97003 -GO <input type="checkbox"/> 97530 -GO <input type="checkbox"/> 97150 -GO <input type="checkbox"/> L _____  Minutes: _____  Units: _____  Initials: _____	<u>Obj. #</u>	<input type="checkbox"/> ADL / Self Help <input type="checkbox"/> Positioning <input type="checkbox"/> Fine Motor Activities <input type="checkbox"/> Sensory Activities <input type="checkbox"/> Visual Motor Activity <input type="checkbox"/> Visual- Perceptual <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Academic Support <input type="checkbox"/> Handwriting Program <input type="checkbox"/> Other _____	___ % correct ___ of ___ correct ___ Not assessed Other: _____ _____ _____ _____	___ Mastered ___ Progress ___ No change ___ Regression Other: _____ _____ _____	___ Continue objective ___ Objective met ___ Initiate new objective ___ Consult ___ Discontinue _____ _____	

**Note: Each clinical service note must include sufficient information to support billing for Medicaid services per the current Medicaid Manual.**