

Guidelines for Documentation of Occupational Therapy

Documentation of occupational therapy services is necessary whenever professional services are provided to a client. Occupational therapists and occupational therapy assistants¹ determine the appropriate type of documentation structure and then record 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], 2008), describes the components and purpose of professional documentation used in occupational therapy.

AOTA's *Standards of Practice for Occupational Therapy* (2010) states that an occupational therapy practitioner² documents the occupational therapy services and "abides by the time frames, format, and standards established by the practice settings, government agencies, external accreditation programs, payers, and AOTA documents" (p. S108). These requirements apply to both electronic and written forms of documentation. Documentation should reflect the nature of services provided and the clinical reasoning of the occupational therapy practitioner, and it should provide enough information to ensure that services are delivered in a safe and effective manner. Documentation should describe the depth and breadth of services provided to meet the complexity of individual client³ needs. The client's diagnosis or prognosis should not be used as the sole rationale for occupational therapy services.

The purpose of documentation is to

- Communicate information about the client from the occupational therapy perspective;
- Articulate the rationale for provision of occupational therapy services and the relationship of those services to client outcomes, reflecting the occupational therapy practitioner's clinical reasoning and professional judgment; and
- Create a chronological record of client status, occupational therapy services provided to the client, client response to occupational therapy intervention, and client outcomes.

Types of Documentation

Table 1 outlines common types of documentation reports. Reports may be named differently or combined and reorganized to meet the specific needs of the setting. Occupational therapy documentation should always record the practitioner's activity in the areas of screening, evaluation, intervention, and outcomes (AOTA, 2008) in accordance with payer, facility, and state and federal guidelines.

¹Occupational therapists are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. Occupational therapy assistants deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2009).

²When the term occupational therapy practitioner is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).

³In this document, client may refer to an individual, organization, or population.

Guidelines For Documentation Of Occupational Therapy

Robin Akselrud



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