[Company Name/Logo here]

HOME HEALTH SKILLS CHECKLIST – CERTIFIED OCCUPATIONAL THERAPIST ASSISTANT

Therapist name: _____ Date: _____

Signature: _____

Indicate the frequency over the past 12 months you have performed these tasks and your skill level with each.	1 = Never, observed only 2 = < 6 times/year 3 = 1-2 times/month 4 = Daily or weekly	1 = Theory, no practical 2 = < 1 year experience 3 = 1-2 years experience 4 = > 2 years experience
	Frequency	**Proficiency**
	Enter a single number based on the above key	**Enter a single number based on the above key**
Patient diagnosis types		
Orthopedic Injury/disorders		
General Medical Disorders		
Neurological Disorders		
Cardiac Disease		
Pulmonary Disease		
Integument Disorders/Wounds		
Documentation Regarding Patients		
Treatment and response		
Goals progression		
Discharge needs/plan		
Objective tests		
Electronic note systems : _____		
Homebound status		
Patient Care		
Modalities		
Ventilators/ Trach		
Hoyer lift transfer		
Therapeutic exercise		
Functional activities		
Splinting		
Prosthetic/orthotic training		
Neuromuscular reeducation		
ADL/IADL training		
Soft tissue mobilization		
Manual therapy		
Cardiopulmonary exercise		
Vital signs: HR, RR, BP		
Wheelchair training/positioning		
Patient / family education		
Balance activities		
Equipment Usage		
Hand Dynometer		
Upper body Ergometer		
Hoyer lift		
Reacher		
Gait Belt		
Sliding Board		

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Theraband		

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