CASE REPORT

Documenting Functional Outcomes

Joan C. Rogers, Janet E. Salta

Key Words: activities of daily living evaluation • dementia • referral and consultation

At the level of individual patient care, the outcomes of occupational therapy practice are evident in documentation. Reichenbach commented that "documentation not only paints a picture of the client, but a picture of what occupational therapists do and how we do it and of our anticipated hopes for the client's future" (1993, p. 5). Health care payers require treatment goals to be measurable and directly relevant to function. Furthermore, changes in function after treatment must be clearly stated. This case report is presented to illustrate functional outcomes and is presented in the form of documentation. After the presentation of the initial evaluation, assessment, and follow-up note is a discussion of the format used for note writing.

This case involves a man potentially at risk due to unmet functional dependency needs. The patient was referred to occupational therapy by a geriatric psychiatrist in an outpatient clinic for older adults. In this setting, the occupational therapist is authorized to make up to two home visits. Additional home visits require further authorization. Patients are contacted by telephone to monitor compliance with recommendations. In the event that a patient is found to be at significant risk in his or her living situation, the occupational therapist, in conjunction with the patient's physician and social worker, will contact protective services. Hence, occupational therapy documentation may be used to initiate and support legal action.

Initial Occupational Therapy In-Home Evaluation and Assessment

Mr. J. is a 79-year-old white, Jewish, retired pharmacist with a baccalaureate degree. He lives with his 76-year-old wife. Mr. J. has Parkinson's disease with related dementia and a history of major depression. His psychiatrist indicated that many of his behaviors are typical for someone with a passive-aggressive personality disorder. He has a history of falling frequently but has not sustained injuries requiring medical care. The stairs, living room, and kitchen have been common fall sites. He is also being evaluated for urinary incontinence. He had lost 14 lb over 3 months and weighed 124 lb at the time of evaluation. His wife appeared to be in good physical health. She reported great stress related to caring for her husband and the restrictions that caregiving places on her own activities. The house is a two-story structure in a middle-income urban neighborhood. There is a bathroom on the first level, but Mr. J.'s bedroom and bathing area are on the second level of the home.

The patient was referred to occupational therapy for in-home assessment by his psychiatrist to determine whether his living situation supports task performance that is safe and optimally independent. Referral was generated after the patient arrived at several outpatient appointments looking unkempt, dirty, and unshaven and...
emanating an unpleasant odor. He used his walker incorrect­ly, that is, at his right side in the manner in which a quad cane is used. Furthermore, the walker was a collaps­ible model, and it was not locked in position. Clinic staff members also witnessed continuous bickering, with hos­tile overtones, between Mr. J. and his wife. Blood tests showed an inadequate therapeutic level of nortryptyline hydrochloride. In addition, Mr. J. receives carbidopa-levi­dopa and lorazepam.

Mr. J.’s first occupational therapy in-home, perform­ance-based assessment took place on October 19, 1993. He was in his pajamas when the therapist arrived at 8:00 a.m., and the pajamas were soiled with food and urine. An offensive odor permeated the house. Functional status was evaluated and assessed in mobility, personal self-care, and selected instrumental activities of daily living (IADLs). The home assessment coincided with the hiring of a male attendant who would help with bathing, grooming, and dressing for 3 hr in the morning.

Evaluation

Functional Mobility

Bed mobility, transfers, walking on level surfaces, stair use, and functional movements were tested. Performance was impaired by parkinsonian symptoms (resting tremors, festination, delayed initiation of movement, decreased strength, and decreased coordination).

Bed mobility. To demonstrate bed mobility, Mr. J. turned onto his left side by grasping the bedside rail on the left side of the bed, with his right hand. He used gravity to assist his return to supine position. In the absence of a bedside rail on the right side of the bed, he grasped the therapist’s arm to support turning onto his right side. He was unable to move toward the head or foot of the bed or to lift his buttocks by bridging with his legs. The bed linens were stained and tangled.

Transfers. For transferring into bed, Mr. J. needed minimal physical assistance to lift his legs onto the bed. In transferring out of bed, he needed moderate physical assistance to move from supine to sitting position and minimal physical assistance to stand. His wife usually assists with bed transfers. Chair transfers were tested from his favorite chair (a sturdy, high-backed, stuffed chair with armrests), which is located in the living room. He executed chair and toilet transfers independently but had difficulty maintaining balance in sitting and rising because his trunk listed from side to side. He needed to push up with his hands on the chair arms and toilet safety rails to stand. Safety rails and a raised toilet seat are available downstairs but not upstairs. When sitting on the toilet, he plopped down hard and attempted to grasp the sink for stabilization. When leaning forward to obtain toilet paper, he braced himself against the wall. When entering and exiting the bathtub, the patient kicked his feet against the side of the tub, causing slight instability. He held firmly onto the towel racks for support; screws were missing from the racks, and they were loose. Although the patient customarily bathes in the bathtub, he refused to demon­strate how he lowers and raises himself from the bathtub. Water was dripping onto the floor from the pipes under the sink. No adaptive equipment was available to assist with transfers.

Walking on level surfaces. Mr. J. was able to locate independently the rooms for all functional mobility tasks. He walks without assistance indoors and outdoors with a wheeled walker. The patient was tested with the footwear he generally wears around the house (ill-fitting cloth slippers with rubber soles). His gait is typically parkinsonian. He usually walked with the walker on his right side and, even when placing it in front of his body, he leaned into it, thus causing a risk to safety. To accommodate clutter throughout the house, he turned the walker sideways and dragged it behind him until the pathway was again wide enough for the walker. When asked to walk more slowly to compensate for festination and to bring the walker closer to him to improve safety, the patient complied but later returned to his usual pattern. Walking was also impeded by furniture blocking the walkways and uneven floor surfaces throughout the house, including scatter and area rugs, raised floor boards, and high thresholds, particularly between the kitchen and living room.

Stair use. Mr. J. customarily walks downstairs mid­morning and remains there until he goes back up to sleep at night. According to self-report, he uses the stairs independently. During performance testing, minimal physical assistance and verbal cues were provided for safety. Verbal cues were given to encourage him to raise his feet high enough to clear each stair during stair climbing, because he was tripping on each stair. Physical assistance (the patient leaned on the therapist) was given for stability to correct for the imbalance caused by tripping and by balancing on one foot while raising the other. To improve balance, the patient tried placing both feet on each stair before progressing. This method did improve safety but the patient rejected it as too slow. Because of the clutter on the stairs, the patient was forced to vary the distance from the handrail, which was on the patient’s right when ascending.

Functional movements. Mr. J. indicated that he avoids bending, stooping, and reaching overhead because of a fear of falling. Performance testing of these movements in isolation suggested that he tends to fall forward when bending at the waist beyond a 45° angle in both a seated and a standing position; he was unable to stoop without holding on to a stable object. He could achieve 135° forward flexion at the shoulder but could not raise up on his toes to extend reach; furthermore, he could not reach above waist height because he lost gripping power. During functional activity testing, problems in bending were observed during dressing and reaching.
during meal preparation. He avoided stooping by kicking items out of his way that dropped to the floor.

Because of the patient's history of falls, Mr. J. was asked to demonstrate how he rises from a fall, a maneuver that he and his wife indicated that he could perform. The patient slid to the carpeted floor from his chair with the assistance of the therapist for controlled movement. He attempted to resume sitting by reversing the movement. When this failed, he tried to turn to face the chair. After multiple tries during a 10-min period, the patient was unable to rise from the floor by himself. Maximal assistance from the therapist and attendant was needed to get the patient back into the chair. Subsequently, the patient acknowledged that neighbors had been summoned to help him; he also indicated that several times he had stayed on the floor for more than an hour before help was available.

**Personal Self-Care**

Feeding, bathing, oral hygiene, shaving, toileting, and dressing were tested. Performance on these tasks was impaired by hand tremors, mobility deficits, and (to a more limited extent) cognitive deficits.

**Feeding and swallowing.** Mr. J. fed himself but did this with difficulty because of bilateral hand tremors that caused him to spill liquids and solids. His attempts to brace his elbow on the table to stabilize his arm for hand-to-mouth movement were unsuccessful. The accuracy of Mr. J.'s hand-to-mouth movement improved when the therapist stabilized both the forearm and wrist on his dominant right arm. His appetite was good during the session, and he ate a large bowl of cereal and drank juice and coffee. He coughed six times while drinking a cup of coffee and appeared to choke once while eating cereal. Mrs. J. reported that her husband is a good eater and that he often coughs and chokes while eating.

**Bathing.** Mrs. J. reported that the patient is accustomed to bathing in the bathtub once per week and sponge bathing at the sink other days; his last sub bath was 11 days ago. The patient refused to gather bathing materials or to bathe. The bathtub was marred by grit, stains, and caked liquid soap.

**Oral hygiene.** The patient reported, and his wife confirmed, that he brushes his natural teeth rarely. He cleans his dentures only when they come loose. The patient was unable to locate task materials. When these were provided, he required physical assistance to put toothpaste (in a pump-type container) on the brush and step-by-step verbal cuing to sustain the task, because task performance was interrupted by his staring blankly into space until prompted by the therapist to continue. Task performance was hindered by bilateral tremors, and at times the patient appeared to stab himself in the mouth with the toothbrush. Mr. J. braced himself continuously against the sink to maintain stability. On request, he removed, soaked, and brushed his dentures; these were caked with food and denture cream.

**Shaving.** Mr. J. indicated that he shaves every other day. He appeared to have more than 1 day's beard. He was unable to find his shaving materials, but when these were provided, he operated the electric razor correctly with two hands. However, he shaved only marginally, leaving many areas unshaved. When given verbal and visual (demonstration) cues to improve task competency, he followed these instructions and shaved adequately. Task performance was hindered by bilateral hand tremors.

**Toileting.** During the session, the patient was prompted to toilet once per hour but toileted only every other hour. The patient has a spillproof urinal at his bedside and a waterproof pad on the bed. When standing to urinate, the patient used the vanity for support. He managed his zipper with difficulty secondary to hand tremors and instability. At the time of the home assessment, the patient smelled of urine; urine and feces stains were apparent on his shorts. He admitted that he does not get up to go to the toilet until he feels that he has to go and that he often has difficulty getting to the bathroom on time. He needed 3 min to walk from his favorite chair to the toilet.

**Dressing.** The bedroom floor and chairs were piled with clutter that impeded the patient's ability to gain access to drawers and closets. The patient indicated that he usually stays in his pajamas. His wife helps him dress when he needs to leave the house. The patient was able to name clothing items but was unable to select clothing for donning. Because he could not recall what he had already selected, he kept selecting the same type of garment. When the therapist selected and laid out clothing on his bed in the order in which it was to be donned, Mr. J. became distressed and fumbled with the clothing by alternately picking up and putting down items. The patient required a verbal cue to begin dressing. Step-by-step instruction was needed to pick up and don each item. The patient managed upper-body (overhead garments) and lower-body clothing with difficulty due to hand tremors and instability. When he bent over from a seated position to don his slippers, he fell forward but was prevented from falling by the therapist. With the use of a foot stool and slight contact guard on his shoulder, he was able to put on his slippers. Dressing was completed in 20 min.

**Instrumental Activities of Daily Living**

IADL testing was limited to the tasks (light meal preparation, medication management, and emergency telephone use) deemed essential for the patient to be able to perform during his wife's frequent absences from the home, which could be as long as 72 hr. Leisure was also assessed to account for his need for cognitive stimulation. The
patient's cognitive impairment was evident in IADLs.

Meal preparation. Mr. J. was unable to locate cereal and milk (which is his breakfast food preference) to prepare his breakfast. The patient knew that the milk was in the refrigerator but was unable to identify the milk carton. When the milk was pointed out to him, he grasped it but lacked sufficient strength to carry the quart container. He located and identified cereal but, because of instability, could not reach overhead to obtain it. When food items were placed on the table, the patient spilled both the cereal and milk on the table and floor due to bilateral hand tremors. Mrs. J. typically sets out her husband's food. When she is not home, he eats dry cereal, and she sets this out for him in advance.

Medication management. Mr. J. could not give the name of his medications (or the number and color of pills), the dose, or the schedule. He did not recognize his pills when they were placed before him. When his medications were organized for him by the therapist and he was told the time of day, he could not identify when he should take his next medication. Mrs. J. typically sets out her husband's medication, but he is responsible for taking it on time.

Emergency telephone use. The patient could neither recall the number to dial to summon emergency help nor suggest an alternative way of obtaining assistance. When given the emergency number in writing (911), he could not dial the telephone correctly on any of four attempts. When the telephone number was dialed for him, he could not provide essential information (such as name and address) because of word-finding problems. Word-finding problems had also been evident when the therapist called to schedule the in-home visit and the patient kept repeating "one hour."

Leisure. Mr. J. spends most of his waking hours sitting in his favorite chair. He is no longer interested in watching television or in religious activities and can no longer do his favorite activity, word puzzles. His social contacts are limited to his wife and daughter. The patient described these relationships as "We pass in the night."

Response to Testing

The patient willingly attempted all tasks with the exception of bathtub transfers and bathing. Despite his word-finding difficulties, he is able to communicate his basic needs and preferences in a face-to-face situation, answer questions about his task performance, and respond in kind to his wife's derogatory comments. At times, his communication difficulties appeared to precipitate frustration (hanging on the table) and sadness (tears). He indicated that he was not concerned about his safety and that things at home were "OK."

Mrs. J. was at home during the assessment. Except for answering some questions about her husband's daily living habits, she did not observe or actively participate in the assessment, for example, by assisting the therapist to locate task materials. She refused to demonstrate how she assisted her husband with bed transfers and dressing, saying, "that is why I hired [the attendant]." She made frequent, unsolicited, negative comments about her husband's task dependencies such as "He is a slob when he eats; it disgusts me." She indicated that she did not understand what everyone is so concerned about.

The newly hired attendant observed the entire assessment but made few comments. He acknowledged that he had no training in caregiving but was willing to learn.

Assessment

In regard to functional mobility, Mr. J. can find his way around his home. He is independent in toilet, chair, and bathtub (by self-report) transfers, walking with the aid of a wheeled walker, and using the stairs with minimal to subjective risks to safety when executing these tasks. He is dependent in bed mobility and bed transfers; minimal to maximal physical assistance is required to perform these maneuvers. He is also dependent in bending, stooping, and reaching overhead, which precipitate instability. Functional mobility is impaired by deficits in task initiation, initial standing balance, trunk control, controlled sitting, coordination, and tremors. His problems in balance are compounded by an unsafe environment characterized by clutter, furniture arrangement that precludes using the walker in a forward position, and uneven floor surfaces.

Regarding personal self-care, Mr. J. is independent in feeding, toileting, and shaving. Feeding is hindered by bilateral hand tremors, toileting by functional mobility deficits and hand tremors, and shaving by poor judgment. These impairments result in marginal task adequacy. The patient appears to be at risk for aspiration. The incontinence reported by his wife could be secondary to functional mobility deficits and inefficiency in managing his zipper because the patient is aware of the need to urinate. He refused to bathe but reported that he can do so independently. Given his functional mobility deficits, his inability to rise from a fall, the lack of safety rails in the bathtub, his unkempt appearance, and body odor (at the time of the home visit and clinic appointments), hygiene is inadequate. The patient is dependent in oral hygiene and dressing; in general, task materials need to be provided along with minimal to moderate physical assistance and verbal cues for sequencing task steps and adequacy of task performance standards.

Regarding IADLs, Mr. J. is dependent in essential tasks that need to be performed when he is unsupervised, including light meal preparation, medication management, telephone use, and leisure. Task performance was impaired by cognitive (perseverance, confusion, anemia) as well as motor impairments. He has little social
contact or sensory stimulation.

In summary, Mr. J. demonstrates dependencies in all three areas of task performance: mobility (bed, bed transfers), personal self-care (oral hygiene, dressing), and IADLs (meal preparation, medication, telephone). Furthermore, even for those tasks that he performs independently (toilet, chair, and bathtub [by self-report] transfers; feeding; toileting; and shaving), there are substantive concerns about the safety and adequacy of task performance. Although the patient and his wife acknowledge the task performance deficits, they discount the risks to safety and adequacy caused by them. The negative interaction between the husband and wife appears to be of long standing, and emotionally they seem to be mutually habituated to it. This antagonistic relationship leads Mrs. J. to take only minimal responsibility for meeting her husband’s dependency needs. Responsibility for meeting many of these needs has now been delegated to the attendant.

The condition of the home, in terms of order and cleanliness, suggests that Mrs. J. is unable or unwilling to assume responsibility for housecleaning. Her stated intent to leave the home more frequently is further evidence of her inability or unwillingness to cope with her husband’s dependencies. The hiring of the attendant enables Mrs. J. to have a much-needed respite from her husband’s care. The attendant, however, is available for only 3 hr a day 5 days a week, has no responsibility for managing Mr. J.’s nutritional needs, and is unskilled in caregiving procedures related to bathing, grooming, and dressing. Because the attendant is unskilled in caregiving, a training session with the therapist was scheduled for the next day. Even with the assistance of the attendant, the following basic needs remain problematic: safe mobility, bed transfers, managing meals and medications, and ability to obtain help when left unsupervised. Previously, Meals-on-Wheels service was attempted, but Mr. J. would not open the door for the volunteer, and the family refused to give the agency a key.

Interventions

The following occupational therapy interventions will be implemented:

- Provide immediate training to attendant for safe body mechanics during bed mobility and transfer tasks.
- Instruct attendant in hierarchial provision of assistance during tasks, beginning with encouragement, verbal cues, demonstration, physical guidance, and total physical support.
- Recommend installation of bathtub safety rails, toilet safety frame, and hand-held shower adapter and purchase or rental of bathtub transfer bench, raised toilet seat, and emergency response system.
- Recommend purchase of scoop bowl, double-handled mug, and antibacterial wipes.
- Provide attendant with handout on how to make zipper pulls from leather straps.
- Provide attendant and wife with handouts on implementation of a medication schedule and implementation of a toileting schedule.
- Refer the patient to speech pathology for swallowing evaluation.
- Contact social worker to provide support services to wife.

Expected Functional Outcomes

Expected functional outcomes for Mr. J. are as follows:

- Patient, with physical support of caregiver, executes safe bed mobility activities as evidenced by use of safe body mechanics in conjunction with caregiver (as taught by the therapist) when moving to foot and head of bed and onto right and left sides by using bedrails.
- After correct installation of bathtub transfer bench, bathtub safety rails, a hand-held shower head, a raised toilet seat, and a toilet safety frame, patient executes safe transfers as evidenced by (a) transferring onto bathtub bench and positioning himself toward the front of the bathtub safely with only verbal cues and standby physical support from caregiver, and (b) lowering and raising himself from the toilet by using the safety frame in a controlled manner without physical support or verbal cues from caregiver.
- Patient uses wheeled walker correctly as evidenced by (a) maintaining 10° of elbow flexion and a bilateral grasp on the rubber supports of the walker, (b) maintaining an erect posture when walking, (c) maintaining the walker within one step in front of himself when walking, and (d) maintaining the walker in a forward (not sideways) position.
- Patient walks in a safe environment as evidenced by (a) lack of scatter and throw rugs (preferably) or presence of nonskid backing on carpeting, (b) lack of furniture blocking walkways, (c) lack of clutter on floor and stairs, and (d) adequate space in pathways to allow walker to be used in proper manner.
- Patient uses stairs safely as evidenced by (a) grasping the rail firmly and placing both feet on each step before proceeding and (b) clearing each step when ascending the stairs.
- After set-up of task materials and purchase and use of a scoop bowl and double-handled mug with drinking spout, patient feeds himself in a controlled manner as evidenced by (a) lack of spillage on clothing and table and (b) no coughing or choking episodes while eating solids or drinking liquids.
- After setup of task materials so that they are easily accessible and verbal cues by caregiver, patient
bristles his teeth and shaves adequately as evidenced by (a) no residue on dentures, (b) no food-stuff visible on remaining teeth, and (c) no stubble remaining on face.

- After implementation of the bath schedule, use of antibacterial wipes for perineal cleansing after toileting, and verbal cues by caregiver, patient maintains adequate body cleanliness as evidenced by (a) lack of body odor at follow-up and during clinic visits, (b) no smell of urine or feces at follow-up and during clinic visits, and (c) no sign of urine stains or feces matter on body or clothing at follow-up and during clinic visits.
- After implementation of a toileting schedule and attachment of a zipper pull on all trousers, patient avoids urinary incontinence as evidenced by lack of wet trousers or smell of urine at follow-up and during clinic visits.
- After placement of clothing in correct order for dressing, patient dresses himself as evidenced by (a) presence of underclothing and outerwear in correct orientation and on correct body parts and (b) fasteners fastened without binding body parts.
- After implementation of medication schedule incorporating verbal cues or telephone calls and paper cup storage system, patient takes his medications correctly when left unsupervised as evidenced by (a) correct medication consumed (supervised), (b) correct medication dispenser empty when attendant arrives in the morning (unsupervised), and (c) no exacerbation of symptoms that medications are prescribed to control.
- After subscription to an emergency response system and instruction in its use, patient manages outgoing emergency calls and incoming daily checkups as evidenced by (a) responding appropriately to incoming checkup calls three out of three times and (b) contacting 911 and providing requested information accurately in three out of three practice trials.
- At 2-week follow-up visit, patient resides in a living situation that supports his safety and functional needs as evidenced by (a) 100% achievement of above outcomes in the home situation, and (b) provision of 24-hr supervision because Mr. J. has deficits with meal preparation, telephone use, and medication management tasks, or (c) placement in a supervised residential setting.

Case Discharge

Ten days after the in-home visit, the occupational therapist was notified by the case manager that Mrs. J. had requested immediate assistance in long-term-care facility placement for Mr. J. because the attendant had quit 3 days earlier.

Format of Occupational Therapy Documentation

The initial note begins with a brief review of relevant demographic, medical, and social factors. The specific reason for referral to occupational therapy is given and sets the parameters for the assessment. The note stresses disability in functional mobility, personal self-care, and ADLs. In the evaluation section, the therapist delineates the specific tasks tested in each area. In general, task disability is described in terms of the impairments that are the hypothesized causes of the disability, the observable cues indicative of the disability, the patient's routine way of performing the task, and any significant features of the social and physical environment. Data obtained by self-report are distinguished from that obtained through performance testing. Interventions attempted during the session and the outcomes achieved through their application are also documented. The evaluation section concludes with a description of the family unit's willingness and ability to cooperate with the evaluation.

The assessment section includes the therapist's overall impression of the patient's functional status and the implications of this status for remaining in the current living situation. Based on the data provided in the evaluation section, performance of each task is rated as independent or dependent. Independent denotes that the patient is able to perform the task himself. Independent ratings may be qualified by concerns about safety or quality. If task performance is rated as dependent, the type and level of assistance needed by the patient is given. Unlike the evaluation section, which is factual, the assessment section calls for clinical judgment. This section indicates how the therapist has synthesized the objective and subjective data to respond to the physician's concern about the patient's living situation.

The expected functional outcomes delineate the criteria that need to be met to move the patient from an at-risk status to a safe functional status and health status. The expected functional outcomes describe the outcome behaviors and the observable cues that designate their achievement. The cues are objective and measurable.

Documentation is facilitated through the use of computer technology. Commonly used text for functional mobility, personal self-care, and ADLs have been converted to macros (computer shortcuts for text and graphics) and can be quickly modified to suit a specific patient. Graphics for patient and caregiver instruction have been converted to macros and are easily incorporated into reports and instruction sheets. New text and graphics are continuously added to the database as new situations arise.

Conclusion

A key professional skill for occupational therapists is documentation of a patient's task abilities and disabilities, the occupational therapy interventions implemented to sup-
port abilities and alleviate or compensate for disabilities, and the patient outcomes resulting from these inter­ventions. Although each facility may have its own format for recording data and synthesizing data into a coherent description of the patient and the occupational therapy program, use of a consistent format from patient to patient provides therapists with an organizing framework for their observations. In addition, it assists others in locating information efficiently and facilitates the review of records for quality improvement and outcome research.

Reference

Ways of Living: Self-Care Strategies for Special Needs

Edited by Charles Christiansen, EdD, OTR, OT(C), FAOTA

This comprehensive hardcover textbook is an ideal reference for practitioners, students, and scholars on the occupational performance area of self-care. Over 15 expert contributors blend theory and experience to provide a decision making framework within which specific self-care issues can be considered by therapists. One of the unique features of this manual is that it contains theoretical and practical information on self-care management and anecdotes from patients and caregivers who have had first-hand experience in coping with self-care challenges. A must for OTs in academic, supervisory, direct intervention, consultation, and research roles. 600 pages, 1994.

Order #1970 $45.00 AOTA member $55.00 nonmember

CONTENTS
• A Social Framework for Understanding Self-Care Intervention • The Personal Meaning of Self-Care: Social, Psychological, and Cultural Issues • Assessment of Self-Care • Principles for Teaching Self-Care Skills • Developmental Deficits in Childhood • Arthritis and Connective Tissue Diseases • Spinal Cord Injuries • Cerebral Lesions (Stroke) • Movement Disorders • Adult Amputations • Management Strategies for People with Severe Burns • Cognitive Deficits • Psychological Conditions • Technology for Self-Care and More!

To order, call 1-800-SAY-AOTA (members), 1-800-377-8555 (TDD users), or (301) 948-9626 (nonmembers). Shipping and handling additional.