splose

Ask AI prompts for Occupational Therapists

Welcome!
These prompts have been designed to give splose AI the context and instructions it needs to draft your most common clinical notes and reports. Each one is a strong starting point, designed to work straight away, but built to be adjusted to match your clinic's documentation style, the patients you see, and the way your team works.

Feel free to modify the structure, add your preferred headings, or change the level of detail to suit your needs.

Do your practitioners share patients?
If multiple practitioners at your clinic see the same patients and have permission to see each other's notes, you may want to scope certain prompts to that practitioner's notes only.
For example, where a prompt reads "the most recent 3 previous progress notes for this patient, you can add "written by the current practitioner" to the end of the instruction to ensure the AI is only pulling in relevant notes as context.

Still like to write rough notes while transcribing the session?
If you like to add written notes (on the LHS of the page) while you're transcribing, ensure you've made it clear that those notes relate to the current session. This is particularly important if your preferred workflow is to copy your recent not into your new note – if you're mixing two pieces of context together, splose AI will get confused trying to determine what is related to today's session vs what you copied from your previous session.

Catch me up on this patient

I am a practitioner preparing for an upcoming occupational therapy session with this patient. Using the information available for this patient, create a concise pre-session briefing so I can review their history and plan before the session begins.

First, get patient details and include only clinically relevant information. Then get previous progress notes from the last 3 months. Then get appointments and support activities from the last 3 months and the next 2 weeks. Using the retrieved information, write a structured pre-session briefing. Use bold headings and dot points.
Fill each section using only what is explicitly documented:

Background
Diagnosis, presenting concerns, and any key clinical context relevant to understanding this patient.

Goals
List each goal documented for this patient. For each goal found, note any documented progress trend across recent progress notes (for example: improving, maintaining, plateauing, or not yet

addressed). Also include whether any goal had been described as achieved in any of the progress notes and the date it was recorded as such.

Last session
Summarise the most recent progress note. Include: the main focus of the session, how the patient presented, what was covered, and what was agreed at the end of the session including any homework, tasks, or strategies the patient committed to.

Upcoming
List the next scheduled appointment or support activity. Include the date, type, and any relevant context documented.

Important instructions:
Use dot points only. Do not use paragraphs.
Do not fabricate or assume any clinical information.
Do not include clinical judgements or interpretations that are not explicitly stated in the notes.
If a section has no relevant documented information, leave it blank rather than filling it with placeholder text.
If this patient has no previous progress notes, summarise patient details only and note that no session history has been documented yet.
Maximum length: one page

Running an initial assessment in a multidisciplinary clinic?
If your clinic shares patient notes across practitioners, consider adding a separate saved prompt with the following section added to it:

Other treating practitioners at this clinic
List any other disciplines currently seeing this patient at this clinic. For each, note the discipline, the treating practitioner's name if documented, and any clinically relevant context from their most recent notes that may inform today's session.

This can help you understand the full picture before an initial session. For example, if a patient is already seeing a dietician or physiotherapist for related concerns that may inform your care.

Write an OT progress note

I am an Occupational Therapist and I have just completed a session with a patient. I need to write a progress note documenting today's session.

First, review any content already written in the current progress note. Then the patient details. Then the most recent 3 previous progress notes for this patient. Then the most recent appointment details, and the next 2 upcoming booked appointments if any exist.

Using the session transcript as the primary source of clinical content and all retrieved information, write a complete occupational therapy progress note for today's session using SOTAP format with these bold headings: Subjective, Observation, Treatment, Assessment, Plan.

Subjective:
Document what the patient and/or their carer reported during today's session. Include presenting concerns, changes since the last session, relevant personal or contextual information shared, and any patient-reported progress or difficulties. Where a carer or parent was present, note who attended and summarise their report separately from the patient's.

Observation:
Document objective clinical observations from today's session. Include the patient's presentation, affect, engagement, and behaviour. Include any observed functional performance, skill level, quality of movement, sensory responses, or participation in activities. Note changes from previous sessions where documented.

Treatment:
Document the interventions, activities, and strategies delivered during today's session. Include the therapeutic rationale where it is evident from the current session's context. Include any education, home program instructions, or carer training provided.

Assessment:
Document a clinical analysis of the patient's occupational performance and progress based on today's session and the patient's documented history. Note progress toward goals, patterns across recent sessions, and any emerging clinical concerns. Reference specific goals where documented.

Plan:
Document agreed next steps, strategies or tasks the patient will work on before the next session, planned interventions, referrals, and follow-up arrangements. Where upcoming appointments are available, use them to inform the timing and sequencing of planned follow-up. This section must contain only clinical content.

Content rules:
Only include information explicitly present in the transcript, current note content, patient details, appointment details, or previous progress notes. Do not fabricate or infer clinical content not present in these sources. Silently discard anything that is not clinically relevant: personal reminders, uncertainties, admin notes and self-corrections. If something is unclear or uncertain, omit it.
Write in plain, direct clinical language. Use short, active and simple sentences. Avoid formal report language, passive constructions, and clinical jargon where plain language conveys the same meaning.
Refer to the patient by their preferred name (not "the patient").
Format each section using concise dot points unless this practitioner's previous notes use paragraphs, in which case match that style.
Output only the completed note. No step narration, no summary of what was done, no closing remarks.

Write an OT initial assessment report

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Intake forms
- Completed Referral form PDF
- Referral documents
- Background files
- Assessment documents

I am an Occupational Therapist and I have just completed an initial assessment with a patient. I need to document today's session in an initial assessment report.

First, review any content already written in the current progress note. Then the patient details, including any referral information. Then the most recent appointment details, and the next 2 upcoming booked appointments if any exist. If you have been provided with any intake forms, assessment documents, or background files as attachments, use these as additional context.

Using the session transcript as the primary source of clinical content and all retrieved information, write a complete occupational therapy initial assessment report. Use the following sections with bold headings. Omit any section entirely where the transcript and patient file contain no relevant information. Do not write placeholder text or note that information was not provided.

Referral and background information:
Why this patient has been referred or has presented for occupational therapy. Include the referral source, reason for referral, relevant diagnoses, and any background documents available in the patient file.

Occupational profile:
The patient's occupational history and relevant life roles. What the patient currently does across self-care, productivity, and leisure. What they want or need to be able to do, and what is getting in the way. Include environmental context, support network, and performance patterns (routines, habits, and roles) as reported during the assessment.

Analysis of occupational performance:
Findings from standardised and non-standardised assessments conducted during this session, organised by domain. Domains may include: self-care and personal activities of daily living, instrumental activities of daily living, mobility and transfers, sensory processing, fine and gross motor skills, cognitive and executive function, social participation, communication, and any other domain assessed. For each domain, document the assessment method used, key findings, and their functional significance. Include assessment scores where obtained.

Summary and analysis:
A clinical interpretation of the patient's overall occupational performance profile. Identify the primary occupational performance issues, the factors contributing to them, and the patient's strengths and available supports. Where relevant, note expected direction of therapy.

Goals and plan of care:
Therapy goals identified or discussed during this assessment. Proposed interventions, frequency, duration, and any referrals or recommendations for other services. Where upcoming appointments are available, use them to inform the timing and sequencing of planned follow-up.

Content rules:
Write in plain, direct clinical language appropriate to occupational therapy practice. Use short, active and simple sentences. Avoid formal report language, passive constructions, and clinical jargon where plain language conveys the same meaning.
Only include information explicitly present in the transcript, current note content, patient details, attachments, or appointment details. Do not fabricate or infer clinical content not present in these sources. Silently discard anything that is not clinically relevant. If something is unclear or uncertain, omit it.
Refer to the patient by their preferred name (not "the patient").
Format each section using concise dot points.
Output only the completed note. No step narration, no summary of what was done, no closing remarks.

Initial assessments usually split over multiple appointments?
If you usually capture context in splose that will serve as additional context for the initial assessment you're completing (for example, you had a call with a parent before conducting the initial consult with the child present) and you wrote notes in separate progress note(s) ahead of the session, make these amendments to paragraphs 2 and 3:

First, review any content already written in the current progress notes. Then the patient details, including any referral information. Then the most recent appointment details, and the next 2 upcoming booked appointments if any exist. Then, review the last 3 progress notes as additional initial assessment information captured outside of this session. If you have been provided with any intake forms, assessment documents, or background files as attachments, use these as additional context. Using the session transcript and previous progress notes as the primary source of clinical content, write...

Write a Functional Capacity Assessment

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Assessment results
- Scored tools
- Clinical observation notes (if not found in historic progress notes)
- Supporting documents

I am an Occupational Therapist and I need to write a Functional Capacity Assessment report for a patient.

First, review the patient details and any referral information available in the patient file. Then the most recent 6 months of progress notes for this patient. Then any content already written in the current progress note. If you have been provided with any assessment results, scored tools, clinical observation notes, or supporting documents as attachments, use these as the primary source of clinical content. If a session transcript is available, use it as additional context.

Using all retrieved information and any attachments, write a complete Functional Capacity Assessment report. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Reason for assessment:
Why this assessment has been requested. Include the referral source, the purpose of the assessment, and any specific questions the assessment is being asked to address.

Background and history:
Relevant medical history, diagnoses, previous therapy, current medications, and any other clinical context documented in the patient file or provided in attachments. Include the patient's living situation, support network, and daily routine where documented.

Assessment methods:
The standardised and non-standardised assessments, clinical observations, and information-gathering methods used in this assessment. List each tool or method used and the date administered where available.

Functional domain findings:
Findings organised by functional domain. For each domain assessed, document the assessment method used, key findings, functional significance, and any scores obtained. Domains may include: self-care and personal activities of daily living, instrumental activities of daily living, mobility and transfers, home and community access, sensory processing, fine and gross motor skills, cognitive and executive function, communication, social participation, and any other domain relevant to this assessment. Only include domains where findings are documented.

Summary of function:
A concise clinical summary of the patient's overall functional capacity across assessed domains. Identify primary areas of functional strength and limitation. Note the impact of functional limitations on the patient's daily life, independence, and participation.

Recommendations:
Clinical recommendations arising from the assessment findings. Include recommended

supports, equipment, environmental modifications, further assessment, or therapy. Each recommendation should be linked to a specific functional finding documented in this report.

Content rules:
Write in formal, objective clinical language appropriate to a functional capacity assessment report. Use third person throughout. Complete sentences and paragraphs are preferred over dot points in this report type, unless assessment findings are best presented in a structured table or list.
Only include information explicitly present in the attachments, transcript, patient details, referral information, previous progress notes, or current note content. Do not fabricate or infer clinical content not present in these sources. If assessment data is incomplete or a domain was not assessed, omit that domain entirely.
Do not include scores, findings, or recommendations not directly supported by documented assessment results or clinical observations.
Refer to the patient by their preferred name (not "the patient").
Output only the completed report. No step narration, no summary of what was done, no closing remarks.

Write a Functional Capacity Assessment (NDIS)

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Finalised Service Agreement PDF (if based off the plan period)
- Assessment results
- Scored tools
- Clinical observation notes (if not found in historic progress notes)
- Supporting documents

I am an Occupational Therapist and I need to write a Functional Capacity Assessment report for a patient.

First, review the patient details and any referral information available in the patient file. Then retrieve the progress notes only finalised during the plan period in the attached service agreement, using the plan start and end dates to scope the retrieval. Then any content already written in the current progress note. If you have been provided with any assessment results, scored tools, clinical observation notes, or supporting documents as attachments, use these as the primary source of clinical content. If a session transcript is available, use it as additional context.

Using all retrieved information and any attachments, write a complete Functional Capacity Assessment report. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Reason for assessment:
Why this assessment has been requested. Include the referral source, the purpose of the assessment, and any specific questions the assessment is being asked to address.

Background and history:
Relevant medical history, diagnoses, previous therapy, current medications, and any other

clinical context documented in the patient file or provided in attachments. Include the patient's living situation, support network, and daily routine where documented.

Assessment methods:
The standardised and non-standardised assessments, clinical observations, and information-gathering methods used in this assessment. List each tool or method used and the date administered where available.

Functional domain findings:
Findings organised by functional domain. For each domain assessed, document the assessment method used, key findings, functional significance, and any scores obtained. Domains may include: self-care and personal activities of daily living, instrumental activities of daily living, mobility and transfers, home and community access, sensory processing, fine and gross motor skills, cognitive and executive function, communication, social participation, and any other domain relevant to this assessment. Only include domains where findings are documented.

Summary of function:
A concise clinical summary of the patient's overall functional capacity across assessed domains. Identify primary areas of functional strength and limitation. Note the impact of functional limitations on the patient's daily life, independence, and participation.

Recommendations:
Clinical recommendations arising from the assessment findings. Include recommended supports, equipment, environmental modifications, further assessment, or therapy. Each recommendation should be linked to a specific functional finding documented in this report.

Support needs and funding justification:
Based on the functional findings and recommendations documented in this report, describe the patient's support needs and provide a justification for NDIS funding. For each recommended support, address the following: the functional limitation that creates the need for this support, why the support is reasonable and necessary under the NDIS, why the support cannot reasonably be provided by informal supports or other funded services, and the anticipated functional or participatory benefit to the patient. Where relevant, reference specific assessment findings or scores from this report to substantiate the claim. Write in plain English (this section is typically read by NDIS planners without a clinical background).

Content rules:
Write in formal, objective clinical language appropriate to a functional capacity assessment report. Use third person throughout. Complete sentences and paragraphs are preferred over dot points in this report type, unless assessment findings are best presented in a structured table or list.
Only include information explicitly present in the attachments, transcript, patient details, referral information, previous progress notes, or current note content. Do not fabricate or infer clinical content not present in these sources. If assessment data is incomplete or a domain was not assessed, omit that domain entirely.
Do not include scores, findings, or recommendations not directly supported by documented assessment results or clinical observations.
Refer to the patient by their preferred name (not "the patient").
Output only the completed report. No step narration, no summary of what was done, no closing remarks.

Write a NDIS progress report

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- The participants NDIS plan
- Assessment results
- Outcome measure data
- Supporting documents

I am an Occupational Therapist and I need to write an NDIS progress report covering this patient's current plan period.

First review the patient details, including any NDIS plan information available in the patient details. Then retrieve the progress notes only finalised during the current NDIS plan period, using the plan start and end dates to scope the retrieval. Then review any content already written in the current progress note (if any). If you have been provided with any supporting documents, assessment results, NDIS plan or outcome measure data as attachments, use these as additional context.

Using all retrieved information and any attachments, write a complete NDIS occupational therapy progress report for this plan period. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Participant and plan details:
A brief summary of the participant's primary diagnosis and any relevant comorbidities, the reason for initially commencing occupational therapy, relevant medical and social history, living situation and support network, and functional presentation at the start of this plan period.

Reason for report:
The purpose of this report and the occupational therapy services delivered under this plan period.

Goals and progress:
Each NDIS goal documented for this patient presented as a heading, followed by a summary of progress toward that goal across the plan period. For each goal include: evidence of progress drawn from progress notes, any outcome measure scores or functional observations that demonstrate change, and a clear statement of whether the goal has been achieved, is progressing, is partially progressing, or has not yet been addressed. Where a goal has not been addressed, note any documented reason.

Barriers to progress:
Any factors that limited progress during this plan period, including attendance, health events, changes in the patient's circumstances, or gaps in service.

Recommendations for next plan period: Recommended supports, therapy frequency, and goals for the next NDIS plan period, based on the patient's current functional status and documented progress. Each recommendation should be linked to a specific finding or pattern documented in this report.

Content rules:
Write in formal, objective clinical language appropriate to an NDIS report. Use third person throughout. Use paragraphs rather than dot points, except under Goals and progress where structured goal-by-goal presentation is required.

Only include information explicitly present in the retrieved progress notes, attachments, patient details, or current note content. Do not fabricate or infer clinical content not present in these sources. Do not summarise or interpret beyond what is explicitly documented across the plan period.
Where outcome measure scores or functional observations are available, use these as evidence of progress rather than relying on general statements.
Refer to the patient by their preferred name (not "the patient").
Output only the completed report. No step narration, no summary of what was done, no closing remarks.

Write a handover or discharge summary

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Previous handover or discharge summaries
- Assessment results
- Review reports
- Supporting documents
- Referral PDFs or forms

I am an Occupational Therapist, and I need to write a handover and discharge summary for this patient.

First, review the patient details, including any referral information listed. Then retrieve the last 3 months of progress notes on file for this patient. Then review any content already written in the current progress note. If you have been provided with any previous handover or discharge summaries, assessment results, referral information or supporting documents as attachments, use these as additional context.

Using all retrieved information and any attachments, write a complete occupational therapy handover and discharge summary. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Patient overview:
A brief summary of the patient's background, interests, primary diagnosis or presenting concerns, and reason for referral to occupational therapy.

Social and contextual information:
Any social, family, or legal context that affects how care is delivered or how the patient is communicated with. This includes custody arrangements, court orders, communication restrictions, safety concerns regarding specific contacts, and any other contextual factors the receiving provider must be aware of before engaging with the patient or their support network. Include only what is explicitly documented in the provided context for this patient.

Services received:
The occupational therapy services provided to this patient, including the approximate duration of service, total number of sessions attended, and the primary areas of therapy focus across the ‘service period’.
Output must return as a list containing:
Services commenced: [date of the first appointment booked for the patient (current

practitioner only) eg. “November 2025”]
Services ended: [date of the last appointment on record booked for the patient (current practitioner only) eg. “March 2026”]
Duration: [the number of months between the first appointment and the last appointment listed above eg. “10 months”]
Sessions attended: [the total number of appointments (current practitioner) eg. “18 sessions”]
Frequency: [eg. “weekly”, “fortnightly”, “monthly”]
Setting: [based on what was documented in the patient’s progress note history, list the settings where sessions were held with the patient eg. “clinic based sessions with two home visits conducted in December 2025 and Febuary 2026”]
Primary areas of therapy focus: [based on what was documented in the patient’s progress note history, list the primary areas of documended focus areas eg. “fine motor skills development, sensory processing and school readiness”]

Goals:
The therapy goals documented as worked on during the service period. For each goal, provide a brief statement of whether it was achieved, partially achieved, or not achieved, with supporting evidence from the progress notes where available.

Progress and outcomes:
A summary of the patient's overall progress and functional outcomes across the service period. Note key improvements, areas of ongoing difficulty, and any significant changes in functional status.

Safety considerations:
Any safety factors relevant to the next provider or carer. Include documented fall risk, home safety concerns, supervision requirements, behaviours of concern, or any other clinical safety information documented in the patient file.

Communication preferences:
The patient's documented communication preferences, including language, AAC use, literacy considerations, and any adjustments required for effective communication.

Funding:
Remaining NDIS funding or plan details where documented in the patient file and relevant to the handover.

Recommendations:
Recommended next steps, ongoing supports, therapy priorities, or referrals for the receiving provider. Each recommendation should be grounded in the clinical picture documented in this summary.

Content rules:
Write in plain, direct clinical language. Use short, active and simple sentences. Avoid formal report language, passive constructions, and clinical jargon where plain language conveys the same meaning.
Only include information explicitly present in the retrieved progress notes, attachments, patient details, or current note content. Do not fabricate or infer clinical content not present in these sources.
The Social and contextual information, Communication preferences and Funding sections are particularly susceptible to assumed or placeholder content. If nothing is explicitly documented for either, omit them entirely.
Refer to the patient by their preferred name (not "the patient").
Format each section using concise dot points.
Output only the completed summary. No step narration, no summary of what was done, no closing remarks.