Quality Care
Home Health Agency, Inc.

PHYSICAL THERAPY CARE PLAN

☐ INITIAL
☐ UPDATED

Diagnosis/ Reason for PT: _____ ONSET: _____

Frequency and Duration: _____ If applicable, portion of Plan of Care assigned to a PTA was discussed, explained to the PTA: ❑ Yes ❑ No ❑ N/A

INTERVENTIONS

Locator #21

Evaluation	Balance training /activities	Teach hip safety precautions
Establish/ upgrade home exercise program ❑ Copy given to patient ❑ Copy attached to chart	Pulmonary Physical Therapy	Teach safe/effective use of adaptive/assist device (specify)
	Ultrasound to _____ at _____ x _____ min	
	Electrotherapy to _____ for _____ min	Teach safe stair climbing skills
Patient/Family education	Prosthetic training	Teach fall safety
Therapeutic exercise	TENS to _____ for _____ min	Pulse oximetry PRN
Transfer training with/without assistance	Functional mobility training	Heat/Cold to _____ for _____ min
Gait training with/without assistance	Teach bed mobility skills	Therapeutic massage to _____ x _____ min

OTHER INTERVENTION/TREATMENT: _____

Note: Each modality specify frequency, duration, amount and specify location: _____

SHORT TERM GOALS

GENERAL
❑ Gait will increase tinetti gait score to _____ / 12 within _____ weeks.
❑ Will improve gait requiring ____ to _____ from _____ to _____ within ____ weeks.

BED MOBILITY
❑ Pt. will be able to turn side (facing up) to lateral (left/right) within ____ weeks.
❑ Pt. will be able to butt scoot within _____ weeks.
❑ Pt. will be able to sit up with/without assistance _____ within _____ weeks.

BALANCE
❑ Will increase tinetti balance score to _____/16 within _____ weeks.
❑ Pt. will be able to reach steady static/dynamic sitting/standing balance with/without assistance _____ within _____ weeks

TRANSFER
❑ Pt. will be able to transfer from _____ to _____ with/without assistance _____ within ____ weeks.

STAIR/UNEVEN SURFACE
❑ Pt. will be able to climb stair/uneven surface with/without assistance _____ steps # _____ within _____ weeks.

MUSCLE STRENGTH
❑ Pt. will be able to hold weigh _____ lb within _____ weeks.
❑ Pt. will be able to oppose flexion or extension force over _____ within _____ weeks.

PAIN
❑ Pain will decrease from ____/10 to ____ /10 within _____ weeks.

ROM
❑ Pt. will increase ROM of _____ by _____ degrees flexion/extension within _____ weeks.

SAFETY
❑ Pt. will be able to use _____ with/without assistance to _____ feet within _____ weeks.
❑ Pt. will be able to propel wheel chair _____ feet within _____ weeks.
❑ HEP will be established and initiated.

LONG TERM GOALS

Locator #22

GENERAL
❑ Gait will increase tinetti gait score to _____ / 12 within _____ weeks.
❑ Will improve gait requiring ____ to _____ from _____ to _____ within ____ weeks.

BED MOBILITY
❑ Pt. will be able to turn side (facing up) to lateral (left/right) within ____ weeks.
❑ Pt. will be able to lie back down within _____ weeks.
❑ Pt. will be able to sit up independently _____ within _____ weeks.
❑ Pt. will be able to self reposition within _____ weeks.

BALANCE
❑ Will increase tinetti balance score to _____/16 within _____ weeks.
❑ Pt. will be able to reach steady static/dynamic sitting/standing balance with/without assistance _____ within _____ weeks

TRANSFER
❑ Pt. will be able to transfer from _____ to _____ with/without assistance _____ within ____ weeks.

STAIR/UNEVEN SURFACE
❑ Pt. will be able to climb stair/uneven surface with/without assistance _____ steps # _____ within _____ weeks.

MUSCLE STRENGTH
❑ Pt. will be able to hold weigh _____ lb within _____ weeks.
❑ Pt. will be able to oppose flexion or extension force over _____ within _____ weeks.

PAIN
❑ Pain will decrease from ____/10 to ____ /10 within _____ weeks.

ROM
❑ Pt. will increase ROM of _____ by _____ degrees flexion/extension within _____ weeks.

SAFETY
❑ Pt. will be able to use _____ independently to _____ feet within _____ weeks.
❑ Pt. will be able to self propel wheel chair _____ feet within _____ weeks.
❑ Pt will be able to finalize and demonstrated to follow up HEP.

ADDITIONAL SPECIFIC THERAPY GOALS

Locator #22

Note: Each modality specify location, frequency, duration, and amount.

Patient Expectation	SHORT TERM Time Frame	LONG TERM Time Frame

DISCHARGE PLANS DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

CARE COORDINATION: ❑ Physician ❑ OT ❑ SN ❑ ST ❑ MSW ❑ Aide ❑ PTA ❑ Other (specify) _____

APPROXIMATE NEXT VISIT DATE: _____

PLAN FOR NEXT VISIT _____

REHAB POTENTIAL: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Equipment needed: _____

Patient/Caregiver aware and agreeable to POC: ❑ Yes ❑ No (explain): _____

Plan developed by: _____ Date _____
Therapist Name/Signature/title

Physician signature: _____ Date _____
Please sign and return promptly, if applicable

Original - Patient Chart **Copy - Patient's Home Chart**

PATIENT NAME - Last, First, Middle Initial	ID#

Cruz & Sanz Health Services, Inc.

PHYSICAL THERAPY

☐ EVALUATION ☐ RE-EVALUATION

DATE OF SERVICE ____/____/____

TIME IN _____ OUT _____

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) _____

TYPE OF EVALUATION
☐ Initial ☐ Interim ☐ Final
SOC DATE ____/____/____
(if Initial Evaluation, complete Physical Therapy Care Plan)

PT ORDERS: ☐ Evaluation ☐ Therapeutic Exercise ☐ Transfer Training ☐ Home Program Instruction ☐ Gait Training ☐ Chest PT
☐ Ultrasound ☐ Electrotherapy ☐ Prosthetic Training ☐ Muscle Re-education ☐ Other: _____

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/ PROBLEM _____
ONSET ____/____/____

MEDICAL PRECAUTIONS:

MEDICAL HISTORY

☐ Hypertension ☐ Fractures
☐ Cardiac ☐ Cancer
☐ Diabetes ☐ Infection
☐ Respiratory ☐ Immunosuppressed
☐ Osteoporosis ☐ Open wound
☐ Other (specify) _____

Assistive Device:
Needs: _____
_____
Has: _____
_____

LIVING SITUATION

☐ Capable ☐ Able ☐ Willing caregiver available
☐ Limited caregiver support (ability/willingness)
☐ No caregiver available

HOME SAFETY BARRIERS:
☐ Clutter ☐ Throw rugs
☐ **Needs** grab bars ☐ Needs railings
☐ Steps (number/condition) _____
☐ Other (specify) _____

BEHAVIOR/MENTAL STATUS

☐ Alert ☐ Oriented ☐ Cooperative
☐ Conf used ☐ Memory deficits ☐ Impaired Judgement
☐ Other (specify) _____

PAIN

INTENSITY: 0 1 2 3 4 5 6 7 8 9 10
LOCATION: _____
AGGRAVATING /RELIEVING FACTORS: _____
PAIN TYPE (dull, aching, etc):
PATTERN (Irradiation):

PRIOR/CURRENT LEVEL OF FUNCTION

Prior level of function (ADL/IADL) Specify: (ADL/IADL On Problematic Areas)

Current level of function (ADL/IADL) Specify: (ADL/IADL On Problematic Areas)

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY RECEIVED AND OUTCOMES

VITAL SIGNS/CURRENT STATUS

BP: _____ T.P.R.: _____ Edema: _____ Sensation: _____
Skin Condition: _____ Muscle Tone: _____ Posture: _____
Communication- _____ Vision: _____ Hearing: _____
Endurance: _____ Orthotic/ Prosthetic Devices: _____

PART 1 – Clinical Record **PART 2 – Therapist**

PATIENT/CLIENT NAME - Last First, Middle Initial | ID#

Cruz & Sanz Health Services, Inc.

PHYSICAL THERAPY (Cont'd.)

☐ EVALUATION ☐ RE-EVALUATION

MUSCLE STRENGTH/FUNCTIONAL ROM EVAL

	AREA	STRENGTH Right	STRENGTH Left	ACTION	ROM Right	ROM Left
UPPER EXTREMITIES	Shoulder			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Elbow			Flex/Extend		
	Forearm			Sup./Pron.		
	Wrist			Flex/Extend		
	Fingers			Flex/Extend		
LOWER EXTREMITIES	Hip			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Knee			Flex/Extend		
	Ankle			Plant/Dors		
	Foot			Inver/Ever		

FUNCTIONAL INDEPENDENCE/BALANCE EVAL

	TASK	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS
BED MOBILITY	Roll/Turn		
	Sit/Supine		
	Scoot/Bridge		
TRANSFERS	Sit/Stand		
	Bed/Wheelchair		
	Toilet		
	Floor		
	Auto		
BALANCE	Static Sitting		
	Dynamic Sitting		
	Static Standing		
	Dynamic Standing		
W/C SKILLS	Propulsion		
	Pressure Reliefs		
	Foot Rests		
	Locks		

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance.
4	Good strength - against gravity with some resistance.
3	Fair strength - against gravity - no resistance - safety compromise.
2	Poor strength - unable to move against gravity.
1	Trace strength - slight muscle contraction - no motion.
0	Zero - no active muscle contraction.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	106% active functional motion.
4	75% active functional motion.
3	50% active functional motion.
2	25% active functional motion.
1	Less than 25%.

FUNCTIONAL INDEPENDENCE SCALE (bed mobility, transfers, W/C skills)

GRADE	DESCRIPTION
5	Physically able and does task independently.
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA)-100% patient/client effort.
2	Minimum assist (Min A)-75% patient/client effort.
1	Maximum assist (Max A)-25% - 50% patient/client effort.
0	Totally dependent-total care/support

BALANCE SCALE (sitting - standing)

GRADE	DESCRIPTION
5	Independent
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA)-100% patient/client effort.
2	Minimum assist (Min A)-75% patient/client effort.
1	Maximum assist (Max A)-25% patient/client effort.
0	Totally dependent for support.

NORMATIVE DATA FOR JOINT MOTION (ROM)

AREA	ACTION/MOVEMENT			
Shoulder	Flex	158°	Extend	55°
	Abd.	170°	Add.	50°
	Int. rot.	70°	Ext. rot.	90°
Elbow	Flex	145°	Ext.	0°
Forearm	Sup.	85°	Pron.	70°
Wrist	Flex	73°	Ext.	70°
Fingers	Flex all	90°	Ext.	0°
Hip	Flex	901-115°	Ext.	25°
	Abd.	45°	Add.	30°
	Int. rot.	45°	Ext. rot.	45°
Knee	Flex	135°	Ext.	10°
Ankle	Plant.	50°	Dors.	20°
Foot	Inv.	30°	Ever.	20°

GAIT

ASSISTANCE: ☐ Independent ☐ SBA ☐ Min. assist ☐ Mod.assist ☐ Max. assist ☐ Unable

SURFACES: ☐ Level ☐ Uneven ☐ Stairs (number/condition)_____ DISTANCE:_____

WEIGHT BEARING STATUS: ☐ FWB ☐ WBAT ☐ PWB ☐ TDWB ☐ NWB

ASSISTIVE DEVICE(S): ☐ Cane ☐ Quad cane ☐ Crutches ☐ Hemi-walker ☐ Wheeled walker ☐ Walker ☐ Other (specify)_____

QUALITY/DEVIATIONS: _____

FOR RE-EVALUATION USE ONLY:

IF A PREVIOUS PLAN OF CARE WAS ESTABLISHED, THEN IT WILL:

☐ CHANGE

☐ NOT CHANGE

PATIENT INFORMATION

PATIENT'S NAME:_____ MED. RECORD #:_____

THERAPIST'S SIGNATURE/TITLE _____ DATE__/__/__ PHYSICIAN'S SIGNATURE _____ DATE__/__/__

** If no changes made to Initial Plan of care, MD signature no required.*

Cruz & Sanz Health Services, Inc.

PHYSICAL THERAPY
WEEKLY SUMMARY REPORT

ACTIVITIES PERMITTED: ☐ Complete Bedrest ☐ Bedrest/BRP ☐ Transfer Bed/ Chair ☐ Up as Tolerated
☐ Full Weightbearing ☐ Partial Weightbearing ☐ No Weightbearing ☐ Independent at Home ☐ No Restrictions
☐ Wheel Chair ☐ Walker ☐ Cane ☐ Crutches ☐ Hoyer Lift ☐ Stair Climbing
☐ Other _____

MENTALSTATUS: ☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Comatose ☐ Depressed ☐ Lethargic
☐ Other _____

HOMEBOUND STATUS DUE TO:
☐ Bed bound ☐ Severe SOB ☐ Ambulates with Assist ☐ Uses W/C, Walker, Cane
☐ Up in Chair with max assist ☐ Severe Weakness ☐ Paralysis ☐ Unable to walk
☐ Balance/Gait - Unsteady ☐ Other _____

Subjective Comments: _____

Specific Safety Issues Addressed: _____

TREATMENT RENDERED (If Pt/CG. instructed. see response below)	INSTRUCTED: Pt.	C.G
☐ Assessment	☐	☐
☐ Therapeutic Exercises	☐	☐
☐ Adaptive Equipment	☐	☐
☐ Transfer Training	☐	☐
☐ Gait Training	☐	☐
☐ EMS, Ultrasound, Massages, Hot/Cold Pack	☐	☐
☐ **Energy Conservation**	☐	☐
☐ **Other**	☐	☐

PLAN OF CARE: PROBLEM - ACTION/PROGRESS TOWARD GOALS - PT'S/CG's RESPONSE TO TREATMENT/INSTRUCTION

☐ Interdisciplinary Communication: ☐ R.N. ☐ P.T./P.T.A. ☐ O.T./OTA ☐ S.L.P. ☐ M.S.W. ☐ H.H.A. ☐ M.D.
Date/Describe: _____

Next Scheduled Visit Date: _____ Plan for Next Visit: _____

Additions to Plan of Care _____
Patient Name _____
Therapist Name/Signature/Title _____ Date: _____

TRINITY HEALTH SERVICES, INC.

PHYSICAL THERAPY REVISIT NOTE

DATE OF SERVICE: _____

TIME IN _____ OUT _____

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

VITAL SIGNS: Temperature:_____ Pulse:_____ ❑ Regular ❑ Irregular Respirations:_____ ❑ Regular ❑ Irregular

Blood Pressure: Right_____/_____ Left_____/_____ ❑ Lying ❑ Standing ❑ Sitting ❑ O2 saturation ____ % (when ordered)

PAIN: ❑ None ❑ Same ❑ Improved ❑ Worse Origin_____ Location(s)_____

Duration_____ Intensity 0- 10_____ Other _____ Relief measures_____

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions ❑ Other (specify)_____

TYPE OF VISIT:
❑ Revisit SOC DATE: _____
❑ Revisit and Supervisory Visit
❑ Other (specify) _____

TREATMENT DIAGNOSIS/PROBLEM AND EXPECTED OUTCOMES:_____

SIGNS/SYMPTOMS THAT SHOULD BE PRESENT TO WARRANT ADMINISTRATION OF THE TREATMENT:_____

PHYSICAL THERAPY INTERVENTION/INSTRUCTIONS (Mark all applicable with an "X".)

Evaluation (B1)	Balance training/activities	Management and evaluation of care plan (B12)	Teach safe stair climbing skills
Establish/Upgrade home exercise program	TENS	Pulmonary Physical Therapy (B6)	Teach safe/effective use of adaptive/assist device (specify)
❑ Copy given to patient	Ultrasound (B7)	Cardiopulmonary PT	
❑ Copy attached to chart	Electrotherapy (B8)	Pain Management	Other:
Patient/Family education	Prosthetic training (B9)	CPM (specify)	
Therapeutic exercise (B2)	Preprosthetic training	Functional mobility training	
Transfer training (B3)	Fabrication of orthotic device (B10)	Teach bed mobility skills	
Gait training (B5)	Muscle re-education (B11)	Teach hip safety precautions	

❑ Modality used _____	❑ Modality used _____	❑ Modality used _____
❑ Location _____	❑ Location _____	❑ Location _____
❑ Frequency _____	❑ Frequency _____	❑ Frequency _____
❑ Duration _____	❑ Duration _____	❑ Duration _____
❑ Intensity _____	❑ Intensity _____	❑ Intensity _____
❑ Other _____	❑ Other _____	❑ Other _____

ROM:_____
STRENGTH:_____
BALANCE:_____
MOBILITY/TRANSFER/AMBULATION:_____
ASSESSMENT/PATIENT'S PROGRESS:_____
SKILLED INTERVENTION (OUTCOME):_____

SAFETY ISSUES

❑ Obstructed pathways
❑ Home environment
❑ Stairs
❑ Unsteady gait
❑ Verbal cues required
❑ Equipment in poor condition
❑ Bathroom
❑ Commode
❑ Others:_____

CARE PLAN: ❑ Reviewed/Revised with patient involvement.
If revised, specify _____

❑ Need for referral (specify)_____

PLAN FOR NEXT VISIT: _____

DISCHARGE PLANS DISCUSSED WITH: ❑ Patient/Family
❑ Care Manager ❑ Physician ❑ Other (specify) _____

BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify)_____

CARE COORDINATION: ❑ Physician ❑ PT/PTA ❑ OT ❑ SLP
❑ MSW ❑ SN ❑ HHA ❑ Other (specify)_____

TEACHING, TRAINING, RESPONSE TO INSTRUCTIONS:

❑ To Patient ❑ To CG ❑ Family ❑ Other: _____
INSTRUCTION ABOUT: ❑ Treatment, Equipment ❑ Other: _____
TEACHING/TRAINING OF _____

PATIENT/FAMILY RESPONSE TO INSTRUCTIONS:
(specify) _____

CARE PLAN UPDATED? ❑ No ❑ Yes (specify, complete Modify Order)_____

If PT assistant/aide not present, specify date he/she was contacted regarding updated care plan: ____/____/____

SIGNATURES/DATES

X _____ / / _____
Patient/Caregiver (if applicable, optional if weekly is used) Date

Complete TIME OUT prior to signing below.
_____ / / _____
Therapist (signature/title) Date

PART 1 - Clinical Record **PART 2 - Therapist**

PATIENT NAME - Last, First, Middle Initial	ID#

REAL BEST HOME HEALTH SERVICES, INC.

PHYSICAL THERAPY IN DEPTH ASSESSMENT

***This In Depth Assessment is to be completed in its entirety. No revisit note required!**

HOMEBOUND REASON: ❒ Needs assistance for all activities ❒ Residual weakness
❒ Requires assistance to ambulate ❒ Confusion, unable to go out of home alone
❒ Unable to safely leave home unassisted ❒ Severe SOB, SOB upon exertion
❒ Dependent upon adaptive device(s) ❒ Medical restrictions
❒ Other (specify)_____

TYPE OF EVALUATION
❒ 13TH VISIT ❑ Supervisory
❒ 19TH VISIT ❒ 30 day visit
❒ Other visit:
Indicate # _____
SOC Date____/____/_____

TREATMENT DIAGNOSIS(ES) / PROBLEMS IDENTIFIED AT START OF CARE

_____
_____

PRIOR LEVEL OF FUNCTION/ AT THE START OF CARE

ADLs ❒ Independent ❒ Needed assistance ❒ Unable ❒ Equipment used &/or assistance needed: _____
_____
In-Home Mobility (gait/wheelchair/scooter): ❒ Independent ❒ Needed assistance ❒ Unable ❒ Equipment used &/or assistance needed:_____
Community Mobility (gait/wheelchair/scooter): ❒ Independent ❒ Needed assistance ❒ Unable ❒ Equipment used &/or assistance needed:_____

CURRENT LEVEL OF FUNCTION

ADLs ❒ Independent ❒ Needed assistance ❒ Unable ❒ Equipment used &/or assistance needed: _____
_____
In-Home Mobility (gait/wheelchair/scooter): ❒ Independent ❒ Needed assistance ❒ Unable ❒ Equipment used &/or assistance needed:_____
Community Mobility (gait/wheelchair/scooter): ❒ Independent ❒ Needed assistance ❒ Unable ❒ Equipment used: _____
_____

LIVING SITUATION

❒ Capable ❒ Able ❒ Willing Caregiver available ❒ Limited caregiver support (ability/willingness) ❒ No caregiver available
Home Safety Barriers: ❒ Clutter ❒ Throw rugs ❒ Needs Grab Bars ❒ Needs railings
❒ Steps (number/condition)_____ ❒ Other(specify)_____

BEHAVIOR/MENTAL STATUS

❒ Alert ❒ Oriented ❒ Cooperative ❒ Confused ❒ Memory deficits ❒ Impaired judgment ❒ Other (specify)_____
_____

CCURRENT PAIN

1 2 3 4 5 6 7 8 9 10

Location(s) _____
Pain (describe)_____
Impact on Function_____
Previous Pain Level _____

CURRENT ADL/IADLs

AREA	STRENGTH		ACTION	ROM (degrees)			TASK	LEVEL OF ASSIST	ASSISTIVE DEVICES/ COMMENTS
	RIGHT	LEFT		RIGHT	LEFT	Bed Mobility	Roll/Turn		
Shoulder			Flex/Extend				Sit/Supine		
			Abd. /Add.				Scoot /Bridge		
			Int.rot/Ext rot.			Transfers	Sit/Stand		
Elbow			Flex/Extend				Bed/Wheelchair		
Forearm			Sup./Pron				Toilet		
Wrist			Flex/Extend				Floor		
Fingers			Flex/Extend				Auto		
			Flex/Extend						
Hip			Abd. /Add.			Balance	Static Sitting		
			Int.rot/Ext rot				Static Standing		
Knee			Flex/Extend				Dynamic Sitting		
Ankle			Plants. /Dors.				Dynamic Standing		
Foot			Inver/Ever			Wheel	Propulsion		
						Chair	Pressure Reliefs		
						Skills	Foot Rests		
							Locks		
							Wheel Chair Mobility		

PATIENT/CLIENT NAME - Last, First, Middle Initial | **ID#**

	MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH		
GRADE	**GRADE**		
5	Normal functional strength – against gravity - full resistance.		
4	Good strength - against gravity with some resistance		
3	Fair strength - against gravity - no resistance – safety compromise.		
2	Poor strength - unable to move against gravity.		
1	Trace strength - slight muscle contraction - no motion.		

Noted Deviations from previous assessments

GAIT:

Braces/prosthesis:_____

Assistance: ❒ Independent ❒ SBA ❒ Min Assist ❒ Mod Assist ❒ Max Assist ❒ Unable
Distance: _____ **Surfaces:** ❒ Level ❒ Uneven ❒ Stairs (number/condition) _____
Weight Bearing Status: ❒ FWB ❒ WBAT ❒ PWB ❒ TDWB ❒ NWB ❑ Other:_____
Patient Has Assistive Device(s): ❒ Standard Cane ❒ Quad Cane ❒ Crutches ❒ Wheel Chair
❒ Walker(specify type) _____ **❒ Other (specify)** _____
Patient Needs Assistive Device(s): ❒ Standard Cane ❒ Quad Cane ❒ Crutches ❒ Wheel Chair
❒ Walker(specify type) _____ **❒ Other (specify) Noted Gait Deviations:** _____
_____

Balance: TUG (On a scale of 1-4) 1 ❒ Less than 10 seconds - High mobility 2 ❒ 10-19 seconds -Typical mobility 3 ❒ 20-29 seconds - Slower mobility 4 ❒ 30+ seconds - Diminished mobility: Interventions: _____
BERG or Tinnetti Forms can be attached if appropriate for evaluation

Sensation (describe & include impact on function if appropriate):

REHAB POTENTIAL/ DISCHARGE PLANS

Rehab Potential Fair: Pt will develop functional mobility within the home care setting	**Rehab Potential:** Guarded with minimal improvement in functional status expected and decline is possible.	**Rehab Potential:** good for stated goals
Rehab Potential: Good with PT able to return to previous level of activity and improvement in functional status in accordance with pt's endurance level.	**Rehab Potential:** Good for PT to be able to follow the plan of care/treatment regimen, and be able to self manage her/his condition.	**Discharge Plan:** Pt will be discharged when Pt is able to function with assistance of caregiver within current limitations at home
Discharge Plan: Pt will be d/c when Pt is able to function independently w/in current limitations @ home	**Other**	**Other**

Current Goals that pertain to current illness	**Progress Toward Goals/ Lack of Progress Toward Goals**
Pt. will _____ assist with bed mobility within_____ ❒ weeks ❒ visits.	
Pt. to demonstrate increased strength of _____ (include specific joint, muscle, and indicate left, right or bilat.) to _____ within _____ ❑ weeks ❑ visits	
Pt. &/or cg will demonstrate comprehension of home exercise program within____ ❒ weeks ❒ visits.	
Pt will verbalize pain relief from ___/10 to ____/10 within _____ ❒ weeks ❒ visits.	
Pt. will demonstrate increased ___ ROM of _____ to _____ degrees within _____ ❑ weeks ❑ visits	
Pt/cg will demonstrate _____transfers with _____ level of assist within____ ❒ weeks ❒ visits.	
Pt will ambulate _____ feet with _____assistance ❒ with ❒ without _____assistive device within _____ ❒ weeks ❒ visits	
Increase _____ sitting balance to _____ within _____ ❑ weeks ❑ visits	
Increase _____ standing balance to _____ within _____ ❑ weeks ❑ visits	
Additional Current Goals	**Progress Toward Goals/ Lack of Progress Toward Goals**
Other:	
Other:	
Other:	

PATIENT/CLIENT NAME - Last, First, Middle Initial	**ID#**

New Goals:	Functional Reassessment Expectation of Progress Toward Goals

If lack of progress to goals: therapist and physician determination of need for continuation

Supportable statement to continue therapy and why goals attainable:

Safety (PT to document noted safety concerns and the training needed to address them):

Treatment Provided This Visit:

Plan for next visit:

Patient/Caregiver response to Plan of Care:

Care coordination/ interdisciplinary communication (to address findings and plans to continue) with: ❒ Physician ❒ SN ❒ Case Manager ❒ PTA ❒ OT ❒ ST ❒ MSW ❒ Other (specify)_____

Changes to the POC:

Patient/Client Signature_____ Therapist Signature/Title _____
Date ____/____ / _____Time In _____ Time Out_____ Date_____/_____/_____ QI Review ❒ Yes Frequency Verified ❒ Yes

PATIENT/CLIENT NAME - Last, First, Middle Initial	ID#

readyCare

ACHC ACCREDITED

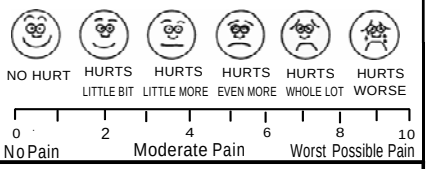
PHYSICAL THERAPY VISIT NOTE

VISIT DATE: ___/___/___

VITAL SIGNS: Pulse:_____ ❑ Regular ❑ Irregular Respiration:_____ ❑ Regular ❑ Irregular

Blood Pressure: Right_____/_____ Left_____/_____ ❑Lying ❑ Standing ❑ Sitting

PAIN: ❑ None ❑ Same ❑ Improved ❑ Worse



Location(s) _____

Frequency: ❑ Constant ❑ Intermittent ❑ Occasional Intensity 1 - 1 0 _____

Relief Measures_____

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness

❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone

❑ Requires assistance to transfer ❑ Severe *SOB, SOB* upon exertion _____

❑ Unable to safely leave home unassisted ❑ Medical restrictions_____

❑ Dependant upon adaptive device(s) ❑ Other (specify) _____

TYPE OF VISIT:

❑ Evaluation ❑ Visit

❑ Visit and supervisory visit

❑ Discharge

❑ Other (specify)_____

TREATMENT DIAGNOSIS/PROBLEM_____

_____

_____

INTERVENTIONS

	Evaluation		Gait training		Pain Management
	Establish rehab. program		Home exercise program upgrade		CPM (Specify)
	Establish home exercise program ❑ Copy given to patient ❑ Copy attached to chart		Pulmonary Physical Therapy		Functionality Mobility Training
	Patient/Client/Family education		Disease Process and Management		Teach safe/effective use of adaptive/ assist device (specify)
	Therapeutic/Isometric/Isotonic Exercises		Energy Conservation Techniques		Teach safe stair climbing skills
	Muscle Strengthening		Prosthetic Training		Teach Bed mobility skills
	Passive/Active/Resistive exercises		Preprosthetic Training		Teach hip safety precautions
	Stretching exercises		Management and Evaluation of Care Plan		Falls Prevention
	Transfer Training		Muscle/Neuro Re-Education		Body Mechanics/Posture Training
	Balance training/activities		Breathing/CP Conditioning Exercises		Pulse Ox
					Other:

Note: Specify location, amount, frequency and duration with any modality

ASSESSMENT/PROGRESS TOWARDS GOALS: _____

_____

_____

_____

ROM: _____

STRENGTH: _____

BALANCE:_____

AMBULATION:_____

TRANSFERS/BED MOBILITY: _____

PATIENT/CAREGIVER RESPONSE: _____

SAFETY ISSUES

❑ Obstructive pathways
❑ Home environment
❑ Stairs
❑ Unsteady gait
❑ Verbal cues required
❑ Equipment in poor condition
❑ Bathroom
❑ Impaired judgement/safety
❑ Other (specify) _____

_____

_____

PLAN FOR NEXT VISIT: _____

_____

_____

DISCHARGE PLANS DISCUSSED WITH:

❑ Patient/Family/Caregiver ❑ Care Manager ❑ Physician

❑ Other (specify) _____

CARE COORDINATION: ❑ None ❑ Physician ❑ PT/PTA

❑ OT ❑ SLP ❑ MSW ❑ SN ❑ HHA ❑ Case Manager

❑ Other (specify) _____

_____

MEDICATION CHANGE. Since last visit ❑ Yes ❑ No

SUPERVISORY VISIT (Complete if applicable)

❑ PT Assistant ❑ Aide ❑ Present ❑ Not present ❑N/A

Supervisory Visit: ❑ Scheduled ❑ Unscheduled

Observation of _____

_____

Teaching/Training of _____

_____

Patient/Family Feedback on Services/Care (specify) _____

_____

Care Plan Updated? ❑ No ❑ Yes (specify)_____

_____

_____

SIGNATURE/DATE:

X _____ ___/___/___

Therapist (signature/title) **Date**

PATIENT NAME - Last, First, Middle Initial _____ **ID#** _____

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ACHC ACCREDITED

PHYSICAL THERAPY EVALUATION

OBJECTIVE DATA TESTS AND SCALES PRINTED ON NEXT PAGE

DATE OF SERVICE _____/_____/_____

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions
❑ Other (specify) _____ ❑ Requires assistance to transfer

SOC DATE _____/_____/_____
(If Initial Evaluation, Complete Physical Therapy Care Plan)

OTHER DISCIPLINES PROVIDING CARE:
❑ SN ❑ OT ❑ ST ❑ MSW ❑ Aide

PERTINENT BACKGROUND INFORMATION

PT ORDERS: ❑ Evaluation ❑ Therapeutic Exercise ❑ Transfer Training ❑ Home Program Instruction ❑ Gait Training ❑ Chest Pt.
❑ Ultrasound ❑ Electrotherapy ❑ Prosthetic Training ❑ Muscle Re-education ❑ Other: _____

TREATMENT/DIAGNOSIS/PROBLEM: _____

MEDICAL HISTORY

❑ Hypertension ❑ Cancer ❑ Immunosuppressed
❑ Cardiac ❑ Arthritis
❑ Diabetes ❑ Other (specify)_____
❑ Respiratory
❑ Osteoporosis
❑ Fractures

LIVING SITUATION

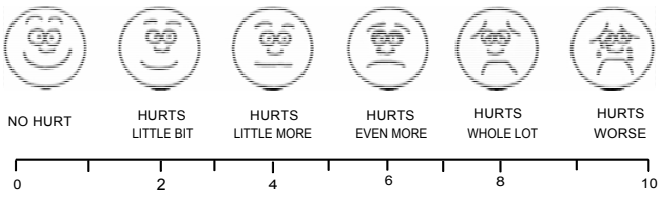
❑ Capable ❑ Able ❑ Willing caregiver available ❑ ALF
❑ Limited caregiver support (ability/willingness)
❑ No caregiver available

HOME SAFETY BARRIERS:
❑ None ❑ Clutter ❑ Throw rugs ❑ Bath bench/equipment
❑ Needs grab bar ❑ Needs railings ❑ Steps (number/condition)
❑ Other (specify) _____

BEHAVIOR/MENTAL STATUS

❑ Alert ❑ Oriented ___x1___ x2___ x3 ❑ Cooperative
❑ Confused ❑ Memory deficits ❑ Impaired judgement
❑ Other (specify) _____

PAIN



LOCATION: _____

FREQUENCY: ❑ Occasional ❑ Intermittent ❑ Continuous

AGGRAVATING/RELIEVING FACTORS: _____

REASON FOR EVALUATION (Diagnosis/Problem/History)

PRIOR LEVEL OF FUNCTION

ADLs: ❑ Independent ❑ Level of assistance _____ ❑ Unable
Equipment Used: _____
Other: _____

IN-HOME MOBILITY (gait or wheelchair/scooter):
❑ Independent ❑ Level of assistance _____ ❑ Unable
Equipment Used: ❑ No AD ❑ Cane/QC ❑ Walker/RW ❑ WC/Scooter
Other: _____

TRANSFER MOBILITY:
❑ Independent ❑ Level of assistance _____ ❑ Unable
Equipment Used: ❑ No AD ❑ Cane/QC ❑ Walker/RW ❑ WC/Scooter
Other: _____

COMMUNITY MOBILITY (gait or wheelchair/scooter):
❑ Independent ❑ Level of assistance _____ ❑ Unable
Equipment Used: ❑ No AD ❑ Cane/QC ❑ Walker/RW ❑ WC/Scooter
Other: _____

VITAL SIGNS/CURRENT STATUS

Blood Pressure: _____
Pulse: _____
Respirations: _____
Skin Condition: _____
Edema: _____
Vision: _____
Sensation: _____
Communication: _____
Hearing: _____
Posture: _____
Activity Tolerance: _____
Muscle Tone: _____
Orthotic/Prosthetic devices: _____

PATIENT NAME - Last, First, Middle Initial

ID#

❑ Continued on Next Page

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PHYSICAL THERAPY EVALUATION (Cont'd)

MUSCLE STRENGTH / FUNCTIONAL ROM EVAL

	AREA	STRENGTH Right	STRENGTH Left	AREA	ROM Right	ROM Left
UPPER EXTREM.	Shoulder			Flex/Extend		
				Abd/Add.		
				Int. Rot./Ext. Rot.		
	Elbow			Flex/Extend		
	Forearm			Sup./Pron.		
	Wrist			Flex/Extend		
	Fingers			Flex/Extend		
LOWER EXTREM.	Hip			Flex/Extend		
				Abd./Add.		
				Int. Rot./Ext. Rot.		
	Knee			Flex/Extend		
	Ankle			Plant./Dors.		
	Foot			Inver./Ever.		

SPINE	AREA	STRENGTH	ACTION	ROM

FUNCTIONAL INDEPENDENCE/BALANCE EVAL

	TASKS	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS
BED MOBILITY	Roll/Turn		
	Sit/Supine		
	Scoot/Bridge		
TRANSFERS	Sit/Stand		
	Bed/Wheelchair		
	Toilet		
	Floor		
	Auto		
BALANCE	Static Sitting		
	Dynamic Sitting		
	Static Standing		
	Dynamic Standing		
W/C SKILLS	Propulsion		
	Pressure Reliefs		
	Foot Rests		
	Locks		

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance
4	Good strength - against gravity with some resistance
3	Fair strength - against gravity - no resistance - safety compromise
2	Poor strength - unable to move against gravity
1	Trace strength - slight muscle contraction - no motion
0	Zero - no active muscle contraction

FUNCTIONAL INDEPENDENCE SCALE (bed mobility, transfers, balance, W/C Skills)

GRADE	DESCRIPTION
6	Independent - physically able and independent
5	Supervision and/or verbal cues - 100% patient effort
4	Contact guard - 100% patient effort
3	Minimum assist (Min A) - 75% patient/client effort
2	Moderate assist (Mod A) - 50% patient effort
1	Maximum assist (Max A) - 25%-50% patient/client effort
0	Totally dependent - total care/support

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION	GRADE	DESCRIPTION
5	100% active functional motion	2	25% active function motion
4	75% active functional motion	1	Less than 25%
3	50% active functional motion		

SAFETY ISSUES

- ❑ Obstructive pathways
- ❑ Home environment
- ❑ Stairs
- ❑ Unsteady gait
- ❑ Verbal cues required
- ❑ Equipment in poor condition
- ❑ Bathroom
- ❑ Impaired judgement/safety
- ❑ Other (specify) _____

GAIT

ASSISTANCE: ❑ Independent ❑ SBA ❑ Contact guard ❑ Minimum assist ❑ Moderate assist ❑ Maximum assist ❑ Unable

SURFACES: ❑ Level ❑ Uneven ❑ Stairs (number/condition) _____ DISTANCE/TIME: _____

WEIGHT BEARING STATUS: ❑ FWB ❑ WBAT ❑ PWB ❑ TTWB ❑ NWB

ASSISTIVE DEVICE(S): ❑ Cane ❑ Quad Cane ❑ Crutches ❑ Hemi Walker ❑ Walker ❑ Wheeled Walker
❑ Other (specify): _____

QUALITY/DEVIATIONS/POSTURES: _____

SUMMARY

INSTRUCTION PROVIDED: ❑ Safety ❑ Exercise ❑ Other (describe) _____

Equipment needed (describe) _____

DISCHARGE DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician
❑ Other (specify) _____

CARE COORDINATION: ❑ None ❑ Physician ❑ SN ❑ PT ❑ OT ❑ ST
❑ MSW ❑ PTA ❑ COTA ❑ Aide ❑ Case Manager
❑ Other (specify) _____

APPROXIMATE NEXT VISIT DATE: ___/___/___

PLAN FOR NEXT VISIT _____

x _____
Therapist Printed Name and Title

x _____ /_____/_____
Therapist (signature) Date

PHYSICAL THERAPY CARE PLAN

Diagnosis: _____ SOC DATE ____/____/____

FREQUENCY AND DURATION: _____

Patient/Caregiver aware and agreeable to POC and Frequency Duration: ❑ Yes ❑ No (explain) _____

INTERVENTIONS

❑ Evaluation	❑ Gait training	❑ Pain Management
❑ Establish rehab. program	❑ Home exercise program upgrade	❑ CPM (Specify)
❑ Establish home exercise program ❑ Copy given to patient ❑ Copy attached to chart	❑ Pulmonary Physical Therapy	❑ Functionality Mobility Training
❑ Patient/Client/Family education	❑ Disease Process and Management	❑ Teach safe/effective use of adaptive/ assist device (specify)
❑ Therapeutic/Isometric/Isotonic Exercises	❑ Energy Conservation Techniques	❑ Teach safe stair climbing skills
❑ Muscle Strengthening	❑ Prosthetic Training	❑ Teach Bed mobility skills
❑ Passive/Active/Resistive exercises	❑ Preprosthetic Training	❑ Teach hip safety precautions
❑ Stretching exercises	❑ Management and Evaluation of Care Plan	❑ Falls Prevention
❑ Transfer Training	❑ Muscle/Neuro Re-Education	❑ Body Mechanics/Posture Training
❑ Balance training/activities	❑ Breathing/CP Conditioning Exercises	❑ Pulse Ox
		❑ Other:

Monitor Vital Signs:

❑ Pulse

❑ Blood Pressure

❑ Respirations

PROVIDE:

❑ U.S. to _____ at _____ warts/cm2 x _____ minutes.

❑ EMS to _____ x _____ minutes.

❑ Heat/Cold to _____ x _____ minutes.

❑ Therapeutic massage to _____ x _____ minutes.

❑ Joint Mobilization _____

SHORT TERM GOALS

❑ Demonstrate effective pain management within _____ weeks

❑ Improve bed mobility to _____ assist within _____ weeks

❑ Improve transfers to _____ assist using _____ within _____ weeks

❑ Decrease pain level to _____ within _____ weeks

❑ Patient to be independent with safety issues in _____ weeks

❑ Improve wheelchair use to _____ within _____ weeks

❑ Patient will ambulate with _____ device with assist within _____ weeks

❑ Patient will be able to climb stairs/uneven surfaces with _____ device with _____ assist within _____ weeks

❑ Ambulation distance will be _____ minutes or _____ feet within _____ weeks

❑ Increase strength of ❑R ❑L UE to _____/5 in _____ weeks

❑ Increase strength of ❑R ❑L LE to _____/5 in _____ weeks

❑ Improve strength of _____ to _____/5 within _____ weeks

❑ Increase ROM of _____ joint to _____ degree flexion and _____ degree extension in _____ weeks

❑ Increase ROM of _____ joint to _____ degree Of _____ in _____ weeks

❑ Demonstrate ROM to WNL within _____ weeks

❑ Improve balance to _____ in _____ weeks

❑ Other _____

LONG TERM GOALS

❑ Return to pre-injury/illness level of function within _____ weeks

❑ Patient will meet maximum rehab potential within _____ weeks

❑ Return to optimal and safe functionality within _____ weeks

❑ Decrease pain level to _____ within _____ weeks

❑ Improve bed mobility to _____ assist within _____ weeks

❑ Improve transfers to _____ assist using _____ within _____ weeks

❑ Patient to be independent with safety issues in _____ weeks

❑ Improve wheelchair use to _____ within _____ weeks

❑ Patient will ambulate with _____ device with assist within _____ weeks

❑ Patient will be able to climb stairs/uneven surfaces with _____ device with _____ assist within _____ weeks

❑ Ambulation endurance will be _____ minutes or _____ feet within _____ weeks

❑ Increase strength of ❑R ❑L UE to _____/5 in _____ weeks

❑ Increase strength of ❑R ❑L LE to _____/5 in _____ weeks

❑ Improve strength of _____ to _____/5 within _____ weeks

❑ Increase ROM of _____ joint to _____ degree flexion and _____ degree extension in _____ weeks

❑ Increase ROM of _____ joint to _____ degree of _____ in _____ weeks

❑ Demonstrate ROM to WNL within _____ weeks

❑ Improve balance to _____ in _____ weeks

❑ Other _____

GOALS: PHYSICAL THERAPY

REHAB POTENTIAL: ❑ Poor ❑ Fair ❑ Good ❑ Other _____

DISCHARGE PLAN: ❑ Patient will be discharged to care of self/caregiver with self/caregiver arranged healthcare

❑ Other _____

ADDITIONAL INFORMATION: _____

❑ PTA is following the case

Plan developed by (Name/Signature/Title) _____ Date _____

PATIENT NAME - Last, First, Middle Initial	ID#

Sanz Health Services

THERAPY DISCHARGE SUMMARY

PATIENT LAST NAME | FIRST NAME | PATIENT #

TYPE OF DISCHARGE: ☐ COMPLETE ☐ PARTIAL - STILL RECEIVING SERVICES OF: ☐ PT ☐ ST ☐ OT ☐ HHA ☐ SN

ADM DATE _____ **DISCH DATE** _____ DR _____

DIAGNOSIS (PRIMARY) _____ ADDRESS _____

_____ CITY, ST _____ ZIP _____

VISITS RENDERED BY: _____ RN _____ HHA _____ PT _____ OT _____ ST _____ MSW

REASON FOR DISCHARGE:
☐ GOALS MET ☐ MOVED OUT OF AREA ☐ OTHER
☐ HOSPITALIZATION ☐ PATIENT EXPIRED
☐ SKILLED NURSING FACILITY ☐ CARE REFUSED
☐ TRANSFER TO ANOTHER AGENCY ☐ SKILLED CARE NO LONGER NEEDED

DISPOSITION	☐ SELF CARE	☐ NH	☐ ACLF	☐ FAMILY CARE	☐ OTHER	
CONDITION	☐ IMPROVED	☐ STABLE	☐ UNSTABLE	☐ DECEASED	☐ REGRESSED	
DEPENDENCY	☐ DEPENDENT	☐ INDEPENDENT	☐ REQUIRES SUPERVISION/ASSIST			
EXERCISES	☐ PASSIVE	☐ ACTIVE	☐ ACTIVE ASSISTIVE	☐ RESISTIVE		
PERFORMED WITH:	☐ R.U.E.	☐ R.L.E.	☐ L.U.E.	☐ L.L.E.	☐ TRUNK	☐ NECK
TRANSFER	☐ HOYER LIFT	☐ CRUTCHES	☐ WALKER			
ACTIVITIES:	☐ W/C	☐ CANE	☐ QUAD CANE	☐ OTHER _____		
GAIT TRAINING:	☐ N.W.B.	☐ P.W.B.	☐ F.W.B.			
	☐ EVEN SURFACES	☐ STAIRS	☐ UNEVEN SURFACES			
ASSISTANCE REQUIRED:	☐ MAXIMUM	☐ MINIMUM	☐ MODERATE	☐ GUARDING	☐ OTHER _____	
DISTANCE AMBULATED:	☐ 20 ft.	☐ 40 ft.	☐ 60 ft.	☐ 80 ft.	☐ 100 ft.	☐ 120 ft.
INSTRUCTED ON HOME PROGRAM:	☐ PATIENT	☐ SIGNIFICANT OTHER	☐ FAMILY			

NARRATIVE: _____

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

Physical Therapy

_____ PATIENT HAS ACHIEVED ANTICIPATED GOALS
_____ PATIENT IS SAFELY INDEPENDENT WITHIN DISEASE LIMITATIONS
_____ ABSENCE OF PAIN
_____ FREE OF CONTRACTURES
_____ RANGE OF MOTION OF ALL JOINTS IS WITHIN NORMAL RANGE
_____ DEMONSTRATES RANGE OF MOTION EXERCISES
_____ DEMONSTRATES MUSCLE STRENGTHENING EXERCISES
_____ DEMONSTRATES TURNING AND POSITIONING SCHEDULE
_____ AMBULATES SAFELY WITH ASSISTIVE DEVICE
_____ AMBULATES SAFELY WITHOUT ASSISTIVE DEVICE

Speech Therapy

_____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
_____ PATIENT HAS ATTAINED MAXIMUM BENEFIT FROM THERAPEUTIC PROGRAM
_____ VERBAL AND SENTENCE FORMULATION AND COMPREHENSION IMPROVED TO MAXIMUM ATTAINMENT WITHIN DISEASE LIMITATIONS

_____ DEMONSTRATES TRANSFER TECHNIQUE AND USE OF SPECIAL DEVICES
_____ DEMONSTRATES ABILITY TO DO SPECIAL TREATMENTS
_____ HEALED INCISION
_____ DEMONSTRATES STUMP WRAPPING AND HYGIENE
_____ DEMONSTRATES TECHNIQUE TO CARE FOR AND PROTECT FUNCTIONING EXTREMITY
_____ DESCRIBES PHANTOM LIMB SENSATION
_____ PATIENT DEMONSTRATES STABILIZATION OF AMBULATION

Occupational Therapy

_____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
_____ DEMONSTRATES KNOWLEDGE OF OPERATION & CARE OF ADAPTIVE EQUIPMENT
_____ DEMONSTRATES ENERGY CONSERVATION/WORK SIMPLIFICATION TECHNIQUES
_____ DEMONSTRATIONS COMPENSATORY & SAFETY TECHNIQUES

PATIENT/S.O. RESPONSE AND ADHERENCE TO TEACHING: ☐ GOOD ☐ FAIR ☐ POOR

THERAPY GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN _____

PATIENT/S.O.GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN _____

COMMENTS: _____

☐ PATIENTS/So. INSTRUCTED ON IMPORTANCE OF ADHERENCE OF EXERCISE PROGRAM, M.D. FOLLOW-UP AND NOTIFY M.D. IF COMPLICATIONS OCCUR. ☐ M.D. NOTIFIED OF DISCHARGE

THERAPIST SIGNATURE _____ DATE _____

White: Medical Records Yellow: Physician

GENTLE CARE Inc.

☐ Visit made
☐ No visit

PHYSICAL THERAPY DISCHARGE SUMMARY

PATIENT _____ TO: DR. _____

CR# _____ HIC# _____ ADDRESS _____

SOC _____ 1st VISIT _____ CITY _____ ZIP _____

D/C DATE _____ ☐ COMPLETE or ☐ PARTIAL – continued services _____

REASON FOR DISCHARGE: _____

NUMBER OF VISITS: PT _____ OT _____ SLP _____ MSS _____ AIDE _____

DIAGNOSES: _____

ADMISSION STATUS	**DISCHARGE STATUS**
Pain due to _____, level _____	Pain due to _____, level _____
ROM _____	ROM _____
Strength and Endurance _____	Str/End _____
Balance _____	Balance _____
Coordination _____	Coordination _____
Bed Mobility _____	Bed Mobility _____
Transfers _____	Transfers _____
Ambulation _____	Ambulation _____
Fine Motor Coordination _____	Fine Motor Coord _____
Sensory/ Perceptual Awareness _____	S/P Awareness _____
Sensory/Perceptual Coordination _____	S/P Coord _____
Receptive Communication _____	Receptive Com _____
Expressive Communication _____	Expressive Com _____
Swallowing _____	Swallowing _____
Knowledge level of	Knowledge level of
Disease Process _____	Disease Process _____
HEP _____	HEP _____
Treatments _____	Treatments _____
Care Management _____	Care Management _____
Safety _____	Safety _____
Other _____	Other _____
Other _____	Other _____

PROBLEMS IDENTIFIED AFTER START OF CARE: _____

SELF CARE ACTIVITY ON ADMISSION: _____

At d/c: ☐ Self Care resumed; or ☐ Assist to be provided by _____,
or ☐ Transferred to _____

CARE PROVIDED: ☐ Observation/Evaluation, ☐ Instruction, ☐ Personal care as ordered,
☐ Treatments as ordered, ☐ Other _____

UNMET NEEDS: _____

INSTRUCTIONS FOR CONTINUING CARE NEEDS: ☐ Equipment management, ☐ Physician follow-up,
☐ Home program, ☐ Other _____

ADDITIONAL COMMENTS/ Referrals made: _____

Physician contacted on _____ and discharge is approved.

Therapist Signature _____ Date _____

PHYSICAL THERAPY
DISCHARGE SUMMARY ADDENDUM

PHYSICAL THERAPY GOALS REACHED

POC (485) GOALS REACHED:

- ❑ PATIENT DEMONSTRATED CORRECT BODY MECHANICS
- ❑ PATIENT AND/OR CG COMPREHEND AND DEMONSTRATED HOME EXERCISE PROGRAM
- ❑ ABLE TO COMPLY WITH EXERCISES: BOTH PASSIVE AND ACTIVE EXERCISE REGIMEN
- ❑ DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM
- ❑ IMPROVED THE USE OF ASSISTIVE DEVICE: _____
- ❑ MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM
- ❑ PATIENT AMBULATED WITH _____ (device) FOR _____ FT WITH _____ ASSIST
- ❑ INCREASED STRENGTH OF ❑ RUE ❑ LUE ❑ RLE ❑ LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.
- ❑ INCREASED RANGE OF MOTION (ROM) OF _____ JOINT TO _____ DEGREE FLEXION AND _____ DEGREE EXTENSION IN ____ WEEKS TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITY: _____.

CARE PLAN SHORT/LONG TERM GOALS REACHED:

GENERAL

- ❑ Gait increased tinetti gait score to _____ / 12
- ❑ Improved gait requiring ____ to _____ from _____ to _____

BED MOBILITY

- ❑ Pt. able to turn side (facing up) to lateral (left/right)
- ❑ Pt. able to lie back down
- ❑ Pt. able to sit up independently _____
- ❑ Pt. able to self reposition
- ❑ IMPROVED BED MOBILITY (INDEPENDENT)

BALANCE

- ❑ Increased tinetti balance score to _____/16
- ❑ Pt. able to reach steady static/dynamic sitting/standing balance with/without assistance

TRANSFER

- ❑ Pt. able to transfer from _____ to _____ with/without assistance
- ❑ INDEPENDENT WITH TRANSFER SKILLS

STAIR/UNEVEN SURFACE

- ❑ Pt. able to climb stair/uneven surface with/without assistance _____ steps # _____

MUSCLE STRENGTH

- ❑ Pt. able to hold weigh _____ lb
- ❑ Pt. able to oppose flexion or extension force over _____

PAIN

- ❑ Pain decreased from _____/10 to _____ /10
- ❑ DEMONSTRATED EFFECTIVE PAIN MANAGEMENT
- ❑ PATIENT EXPERIENCED A DECREASE IN PAIN

ROM

- ❑ Pt. increased ROM of _____ by _____ degrees flexion/extension

SAFETY

- ❑ Pt. able to use _____ independently to _____ feet
- ❑ Pt. able to self propel wheel chair _____ feet
- ❑ Pt able to finalize and demonstrated to follow up HEP.

OTHER:

_____
_____
_____
_____
_____

ADDITIONAL SPECIFIC THERAPY GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

DISCHARGE INSTRUCTIONS DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

CARE WAS COORDINATED: ❑ Physician ❑ OT ❑ SN ❑ ST ❑ MSW ❑ Aide ❑ PTA ❑ Other (specify) _____

- ❑ DISCHARGED: PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
- ❑ RETURNED TO INDEPENDENT LEVEL OF SELF CARE.
- ❑ ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____

REHAB STATUS: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

- ❑ DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED
- ❑ ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE
- ❑ ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED.

Goals documented by: _____ Date _____
Therapist Name/Signature/title

PATIENT NAME - Last, First, Middle Initial	ID#