MRN#: ____________________

PATIENT NAME: ______________________________ START: ____________

STOP: ____________

THERAPIST: ______________________________ DOC: ____________

TRAVEL: ____________

VISIT DATE: ______________________________ MILES: ____________

PT ADMIT ASSESSMENT (REV 4)

01: BHC Patient Info

Hospital Course: State why the patient was in the hospital or ECF.

PMH: Provide past medical history.

Discharge Plans*: Enter your discipline discharge plan. Circle one of the following:

- Pt will be DC to self care under physician supervision.
- Pt will be DC to CG provided/assisted care under Physician supervision.

Precautions: Check any applicable boxes.

Hospital Course:

PMH:

Discharge Plans:

Precautions:

☐ Cardiac ☐ Back ☐ Aspiration ☐ Hip ☐ Oxygen Use ☐ Falls ☐ None

☐ Other

02: BHC PT Patient Condition – Activities/Limitations

Activities Permitted: Check any box that applies.

If Other, please specify.

Functional Limitations: Check any box that applies.

If Other, please specify.

Activities Permitted:

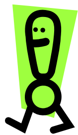
☐ Complete Bedrest	☐ Bedrest BRP	☐ Up as Tolerated
☐ Transfer Bed/Chair	☐ Exercise Prescribed	☐ Partial Weight
☐ Independent at Home	☐ Crutches	☐ Cane
☐ Wheelchair	☐ Walker	☐ No Restrictions
☐ Other		

Functional Limitations:

☐ Amputation	☐ Bowel/Bladder (Incontinence)	☐ Contracture
☐ Hearing	☐ Paralysis	☐ Endurance
☐ Ambulation	☐ Speech	☐ Legally Blind
☐ Dyspnea w/Minimal Exertion	☐ Other	

03: BHC PT Weight Bearing Status

Check the boxes as they apply.



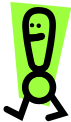
You must address upper and lower extremities.

	LLE	LUE	RLE	RUE
FWB	☐	☐	☐	☐
WBAT	☐	☐	☐	☐
PWB	☐	☐	☐	☐
TTWB	☐	☐	☐	☐
NWB	☐	☐	☐	☐

04: BHC Pain Location 1 – Pg 1 – SS (PT Admit)(4)

Verify Pain Assessment*:
Circle one of these options:

1) See Assessment Below
2) Not Assessed
3) No Problem



You should **never** chose *Not Assessed.*

If you select *See Assessment Below*, check the applicable **Location** box, and continue filling out this page.

Patient Describes Pain as:
Circle one of the following options:

Ache
Burning
Dull
Sharp
Stabbing
Throbbing

Verify Pain Assessment:

Location:

Abdomen | Arm | Back | Chest
Generalized | Head/Neck | Leg | Shoulder
Other

Patient Describes Pain as:
Pain Intensity Level Now:
Pain Intensity at Worst:
Pain Intensity at Best:
Acceptable Level of Pain:
Pain Quality:
Onset:
Frequency:
Duration:
Note:

Pain Intensity Level Now: Use the scale from 0 to 10, where 10 is the worst.

Pain Intensity at Best: Use the scale from 0 to 10, where 10 is the worst.

Pain Intensity at Worst: Use the scale from 0 to 10, where 10 is the worst.

Acceptable Level of Pain: Use the scale from 0 to 10, where 10 is the worst.

Pain Quality: Circle one of the following options:

1 - Bone
2 - Nerve
3 - Somatic
4 - Visceral
5 - Other
6 - N/A

Onset: Provide info as applicable in this field.

Frequency: Provide info as applicable in this field.

Duration: Circle one of the following options:

Constant
Intermittent
Occasional
With Movement

Note: Use this field to provide any other pertinent information regarding the patient's pain.

05: BHC Pain Location 1 – Pg 2 – SS (PT Admit)(5)

Barriers to Pain Control: Check the appropriate box(es).

Pain Relief Measures: Check the appropriate box(es).

If you select *Medication*, you will need to provide the name of the medication and the response to medication.

Effects of Pain Relief Measures*: Check the appropriate box.

Impact on Functional Activity: Provide any additional pertinent information.

Barriers to Pain Control

☐ Culture ☐ Education ☐ Philosophy of caregiver
☐ Physical ☐ Emotional ☐ Spiritual
☐ Financial ☐ Other

Pain Relief Measures

☐ Rest
☐ Medication
☐ Other

Effects of Pain Relief Measures

☐ Good ☐ Fair ☐ Poor

Impact on Functional Activity:

☐ **There are no other Pain locations. Check this box to Clear & Disable the following Pain forms. UNcheck to re-enable the forms.**

Document Pain Location 2

If there are no other pain locations, check this box. If there are multiple pain locations, go to the next page of this document.

06: BHC Pain Location 2 – Pg 1 – SS (PT Admit)(5)

Verify Pain Assessment:

Location:
- [ ] Abdomen
- [ ] Arm
- [ ] Back
- [ ] Chest
- [ ] Generalized
- [ ] Head/Neck
- [ ] Leg
- [ ] Shoulder
- [ ] Other

Patient Describes Pain as:
Pain Intensity Level Now:
Pain Intensity at Worst:
Pain Intensity at Best:
Acceptable Level of Pain:
Pain Quality:
Onset:
Frequency:
Duration:
Note:

07: BHC Pain Location 2 – Pg 2 – SS (PT Admit)(5)

Barriers to Pain Control
- [ ] Culture
- [ ] Education
- [ ] Philosophy of caregiver
- [ ] Physical
- [ ] Emotional
- [ ] Spiritual
- [ ] Financial
- [ ] Other

Pain Relief Measures
- [ ] Rest
- [ ] Medication
- [ ] Other

Effects of Pain Relief Measures
- [ ] Good
- [ ] Fair
- [ ] Poor

Impact on Functional Activity:

- [ ] There are no other Pain locations. Check this box to Clear & Disable the following Pain forms. UNcheck to re-enable the forms.

Document Pain Location 2

10: BHC Vital Signs – SS (PT Admit) (4)

You should take vital signs on **all patients**.

For Pulse:

Specify Site: Apical or Radial
Specify Quality: Regular or Irregular

For Blood Pressure:

Specify Arm: Left or Right
Specify Position: Lying, Sitting, or Standing.

Be sure to complete the infection surveillance field. Of specific concern is if a patient develops a new UTI or wound.

Temp: [ ] Oral [ ] Tympanic [ ] Rectal [ ] Axillary

Pulse
Pre-Exercise Rate: Site: Quality:
Post-Exercise Rate: Site: Quality:

Blood Pressure
Pre-Exercise B/P: Arm: Position:
Post-Exercise B/P: Arm: Position:

Respirations: [ ] Easy [ ] Labored

[ ] **WNL Lung Sounds**

Lung Sounds:
Left [ ] L Clear [ ] L Diminished [ ] L Rales [ ] L Rhonchi [ ] L Wheezes
Right [ ] R Clear [ ] R Diminished [ ] R Rales [ ] R Rhonchi [ ] R Wheezes

Pulse Oximetry: **Height (Inches):** **Weight (lbs):**

Notes:

BHC Infection Surveillance [ ] N/A **Type:**

Date Infection Diagnosed:

Culture Positive for:

Treatment Placed on:

Next

11: BHC Safety/Falls/Abuse – SS PT Admit

Verify Safety Hazards*:
Circle one of the following:

1] See Assessment Below
2] Not Assessed
3] No Problem

You should **never** chose *Not Assessed.*

Safety Hazards: Check the appropriate boxes.

Indications of Abuse/Neglect/ Exploitation: Check if applicable.

If you select either of these boxes, document what these indicators are. Consider a Case Conference and referral to MSW.

Fall #1:
Only document if there is a current fall or an old fall that resulted in hospitalization.

Verify Safety Hazards: 1] See Assessment Below

Safety Hazards:
No Safety Hazards | Structurally Unsound | Obstructed Exits/ Entrances | Unsafe Mats/ Throws
Inadequate Heat | Inadequate Lighting | Inadequate Plumbing | Unsafe Appliances
Lacks Safety Devices | Steep Stairs | Unsafe Storage of Dangerous Objects/ Substances | Lead Paint Present
Cluttered Living Arrangements | Other

Indicators of Abuse/Neglect/Exploitation
Physical Indicators
Behavioral Indicators

Fall #1 MM/DD/YYYY | Injury
Location: | MD Notified
Witnessed

Fall #2 MM/DD/YYYY | Injury
Location: | MD Notified
Witnessed

Fall #3 MM/DD/YYYY | Injury
Location: | MD Notified
Witnessed

1. Indicate the **day** of the fall.

2. For **Location**: Circle one of the following:

1 = bathroom
2 = bedroom
3 = kitchen
4 = outdoors
5 = other

3. You will need to **check any of the applicable boxes** – *Injury*, *MD Notified*, or *Witnessed.* When you check any of these, a field will open up for you to enter details.
   - Examples of *Injury*: Include type (e.g. swelling, laceration, bruise, etc.)
   - Examples of *MD Notified*: "Spoke to Susie Q. at Dr. Doe's office re:…"
   - Examples of Witnessed: "Fell while ambulating down stairs."

4. Any notes should be entered in the blank field below **Location**. Examples include:
   - "Patient reports pain/ no pain."
   - "Caregiver present during fall."

12: BHC Patient Home Info

Living Arrangements: Circle one of the following:

Alone
Assisted Living
Other
SNF
With Family/Son/Dtr
With Spouse

Caregiver Present: Check *Yes* or *No*.

Home: Circle one of the following:

1 story
2 story
Apartment
Other

Living Arrangements:
Caregiver Present: Yes No
Home:
Steps to Enter:
Steps Inside:
Ramp:

Steps to Enter: Circle *Yes* or *No*.

If Yes, indicate # of steps and if there are handrails (Yes or No)

# of Steps Handrails:

Steps Inside: Circle *Yes* or *No*.

If Yes, indicate # of steps and if there are handrails (Yes or No)

# of Steps Handrails:

Ramp: Circle *Yes* or *No*.

13: BHC PT Prior Mobility/ADL/DME's

Prior Level of Mobility: Check either *Independent* or *Device Used.*

If you select *Device Used*, circle one of the following:

Cane
Cane-Quad
Other
Walker-Rolling
Walker-Standard
Wheelchair

Prior Level of ADL's: Check one of the four boxes.

If you select *Requires Assistance* or *Other*, provide additional information. Examples of *Requires Assistance* are:

Mod assist for advances ADLs
Verbal cues
P.M. assistance

ADL DME at Home: Check the appropriate boxes. If you select *Adaptive Equipment*, provide the name of the equipment that the patient has in the home. (e.g. reacher).

Prior Level of Mobility:
- [ ] Independent
- [ ] Device Used

Prior Level of ADL's:
- [ ] Independent
- [ ] Requires Assistance
- [ ] 24 hour Caregiver
- [ ] Other

ADL DME at Home:
- [ ] Tub Bench
- [ ] Shower Chair
- [ ] Commode
- [ ] Adaptive Equipment

<u>14: BHC Sensory Status</u>

Cognition: Check the appropriate box(es).

Follows Commands: Circle *Yes* or *No*.

Safety: Check the appropriate box.

Perception: Check the appropriate box. If *Impaired* is selected, provide details

Examples might include: neurological perception deficit (i.e. neglect); proprioception

Sensation: Check the appropriate box. If *Impaired* is selected, provide details
Examples might include: numbness (include the location of numbness); parasthesia

Cognition:
☐ Alert ☐ Oriented ☐ Lethargic
☐ Depressed ☐ Forgetful ☐ Agitation

Follows Commands: [▾]

Safety:
☐ Good ☐ Fair ☐ Poor

Perception:
☐ WFL ☐ Impaired

Sensation:
☐ WFL ☐ Impaired

Vision:
☐ WFL ☐ Impaired
☐ Glasses or Contacts

Hearing:
☐ WFL ☐ Impaired ☐ Hearing Aid

Vision: Check the appropriate box. If *Impaired* is selected, provide details
Examples might include: macular degeneration

Hearing: Check the appropriate box. If *Impaired* or *Hearing Aid* are selected, circle one of these *Both*, *Right*, or *Left*.

15: BHC PT Eval – Motor Status

Enter measurements in the fields for **Hip**, **Knee**, and **Ankle**.

In the **Comments** field, document what position (supine, sitting) patient was in when you did knee measurements.

For a TKA, make sure to include PROM measurements in the Comments field.

	LLE		RLE	
Hip:	**ROM**	**MMT**	**ROM**	**MMT**
Flexion (120)				
Extension (0)				
Abduction (45)				
Adduction (0)				
Internal Rotation (0-30)				
External Rotation (0-45)				
Knee:				
Flexion (120)				
Extension (0)				
Ankle:				
DF (0-25)				
PF (0-50)				
IN (0-30)				
EV (0-15)				

Comments:

Next

16: BHC PT Eval – Strength/ROM

RUE Strength: Circle one of the following:

If you select *Other*, provide additional information.

3+/5
3/5
4-/5
4/5
Other
WNL

LUE Strength: Circle one of the following:

If you select *Other*, provide additional information.

3+/5
3/5
4-/5
4/5
Other
WNL

RUE Strength:

LUE Strength:

RUE ROM: WFL Deficit

LUE ROM: WFL Deficit

Neck ROM: WFL Deficit

Trunk ROM: WFL Deficit

Comments:

RUE ROM: Check the appropriate box.

LUE ROM: Check the appropriate box.

Neck ROM: Check the appropriate box.

Trunk ROM: Check the appropriate box.

If you select *Deficit* in any of the above four areas, provide the *% Deficit* and the *Location*.

Comments: Use this field to enter any other pertinent information.

17: BHC PT Eval – Mobility/Transfer/Bal/Gait

Bed Mobility: Circle one of the following:

CGA
IND
MAX A
MIN A
MOD A
SBA
UNABLE

Transfers: Circle one of the following:

CGA
IND
MAX A
MIN A
MOD A
SBA
UNABLE

Balance: Circle one of the following:

Fair
Fair +
Fair –
Good
Good +
Good –
Poor
Poor +

Bed Mobility: Rolling Right: Rolling Left: Supine to Sit: Sit to Supine:
Note:
Transfers: Seated Scoot: Sit to Stand: Stand to Sit: Sit to Chair:
Note:
Balance: Sitting - Static: Sitting - Dynamic: Standing - Static: Standing - Dynamic:
Note:
Gait - Patterns/Deficits:
1. Antalgic: 2. Ataxia: 3. Forward Flexed:
4. Stride Length: 5. List to: 6. Heel-Strike:
7. Cadence: 8. BOS: 9. Foot placement accuracy:
Note:
Distance:
Devices:
Assistance Required:

Provde any additional observations/information in the **Note** field that accompanies each of these areas. Examples include: *Requires encouragement* or *Requires verbal cues.*

Gait Patterns/ Deficits:

1. Antalgic: Circle Mild, Moderate, or Severe.
2. Ataxia: Circle Mild, Moderate, or Severe.
3. Forward Flexed: Circle Mild, Moderate, or Severe.
4. Stride Length: Circle Decreased or Increased.
5. List to: Circle Left or Right.
6. Heel-Strike: Circle Absent or Decreased.
7. Cadence: Circle Increased or Decreased.
8. BOS: Circle Increased or Decreased
9. Foot placement accuracy: Circle Fair, Good, or Poor.

Any additional observations can be entered in the **Note** field that follows.

Distance: Enter the distance (in feet) that the patient ambulated.

Devices: Circle one of the following:

Cane
Cane-Quad
Other
Walker-Rolling
Walker-Standard
Wheelchair

Assistance Required: Circle one of the following:

CGA
IND
MAX A
MIN A
MOD A
SBA
UNABLE

18: BHC PT Eval – TUG & Functional Reach

Trial 1 (seconds): Provide the seconds.

Trial 2 (seconds): Provide the seconds.

AVG (second): Provide the average of these two trial times.

Functional Reach Test: Provide the number of inches in the appropriate field.

TUG (Timed Up and Go) Test:

MEAN: Age	Male	Female
60 - 69	8	8 seconds
70 - 79	9	9 seconds
80 - 89	10	11 seconds

Trial 1 (seconds) = : ______

Trial 2 (seconds) = : ______

AVG (seconds) = : ______

Functional Reach Test:

MEAN: Age	Male	Female
41 - 69	15	14 inches
70 - 87	13	10.5 inches

______ **Inches**

19: BHC PT Tinetti Assessment – Balance – SS

1. Sitting Balance: Circle one of the following:

Leans or slides in chair
Steady, safe

2. Arises: Circle one of the following:

Able w/out using arms
Able, uses arms to help
Unable w/out help

3. Attempts to Rise: Circle one of the following:

Able to arise, 1 attempt
Able, requires > 1 attempt
Unable w/out help

4. Immediate Standing Balance (1st 5 sec): Circle one of the following:

Steady w/out walker/other support
Steady, uses walker/other support
Unsteady (swaggers, moves ft, sway)

5. Standing Balance: Circle one of the following:

Narrow stance w/out support
Steady,wide stance/heels>4"/oth sup
Unsteady

6. Nudged: Circle one of the following:

Begins to fall
Staggers, grabs, catches self
Steady

7. Eyes Closed: Circle one of the following::

Steady
Unsteady

8. Turning 360 degrees (steps & steady):

For **Steps**: Circle one of the following:

Continuous steps
Discontinuous steps

For **Steady**: Circle one of the following::

Steady
Unsteady (grabs, staggers)

9. Sitting Down: Circle one of the following::

Safe, smooth motion
Unsafe-misjudged dist/falls->chair
Uses arms or not a smooth motion

20: BHC PT Tinetti Assessment – Gait – SS

10. Initiation of Gait: Circle one of the following:

Any hesitancy;multi-start attempts
No hesitancy

11. Step Length & Height

Rt Swing Ft Length: Circle one of the following:

Does not pass left stance ft w/step
Passes left stance foot

Rt Swing Ft Height: Circle one of the following:

Rt foot completely clears floor
Rt foot does not clear floor w/step

Lt Swing Ft Length: Circle one of the following:

Does not pass Rt stance ft w/step
Passes right stance foot

Lt Swing Ft Height: Circle one of the following:

Left foot completely clears floor
Lt foot does not clear floor w/step

12. Step Symmetry: Circle one of the following:

Right & left step length not equal
Right/left step length appear equal

13. Step Continuity: Circle one of the following:

Steps appear continuous
Stopping/discontinuity between step

14. Path: Circle one of the following:

Marked deviation
Mild/mod dev or uses walking aid
Straight without walking aid

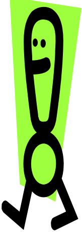
15. Trunk: Circle one of the following::

Marked sway or uses walking aid
No sway,but flexion-knees/back;arms
No sway; flexion; arms; walking aid

16. Walking Stance: Circle one of the following::

Heels almost touching while walking
Heels apart

21: BHC Homebound Status – Pg 1 – SS



For these three areas on this form, select all that apply. This serves as justification for home care eligibility.

Homebound Limitations*: Check the appropriate box(es).

If you select *Other*, provide additional information.

Requires Assistance: Click in the appropriate box(es).

If you select *Other*, provide additional information.

Patient requires following assistive device(s): Click in the appropriate box(es).

If you select *Other*, provide additional information.

Homebound Limitations:

- [ ] Bed Bound
- [ ] Chair Bound
- [ ] Medically restricted to home
- [ ] Unable to ambulate more than 10 ft
- [ ] Unable to ambulate more than 20 ft
- [ ] None
- [ ] Other

Requires Assistance:

- [ ] Frequent rest periods
- [ ] Ambulance to leave home
- [ ] Assist of 1 person to ambulate/ transfer
- [ ] Assist of 2 people to ambulate/ transfer
- [ ] Mechanical device for transfer
- [ ] Requires assistance due to mental confusion
- [ ] None
- [ ] Other

Patient requires following assistive device(s):

- [ ] Cane
- [ ] Pronged Walker
- [ ] Walker
- [ ] Wheeled walker
- [ ] Wheelchair
- [ ] Crutches
- [ ] Specialized Orthotics
- [ ] Prosthesis
- [ ] Oxygen
- [ ] Slideboard
- [ ] None
- [ ] Other

Note:

22: BHC Homebound Status – Pg 2 – SS (PT Admit)

With activity of leaving home…: Check the appropriate box(es).

If you select *Other*, provide additional information.

Homebound status is primarily due to*: Check the appropriate box(es).

If you select *Other*, provide additional information.

With activity of leaving home the patient may experience:

- [ ] Dizziness/vertigo
- [ ] Angina/chest pain
- [ ] Pain
- [ ] Swelling
- [ ] Respiratory distress/ Dyspnea/SOB
- [ ] Unsteady gait/Frequent falls/Poor balance
- [ ] Mental confusion
- [ ] Serious risk of infection
- [ ] Incontinence of urine
- [ ] Incontinence of stool
- [ ] None
- [ ] Other

Homebound status is primarily due to:

- [ ] Infected/Drainage/ Large/Painful wound
- [ ] Profound generalized weakness
- [ ] Morbid obesity
- [ ] Orthopedic condition
- [ ] Cardiac condition
- [ ] Neurologic condition
- [ ] Lung condition
- [ ] Immunosupression
- [ ] Psychological impairment
- [ ] Peripheral vascular disease
- [ ] Urinary condition
- [ ] Bowel condition
- [ ] None
- [ ] Other

Note:

23: BHC PT Assessment Summary (PT Admit) 1

Summary of Impairment: This is where you will summarize your assessment results. Provide all the identified problems. Make sure to include objective measurements.

Is homebound Physical Therapy reasonable and necessary: Check *Yes* or *No*.

Rationale: Enter your reason why homebound PT is reasonable and/or necessary.

Discussed Careplan with Patient?: Check *Yes*, *No*, or *Other*.

- You can select *Yes* and *Other*.
- If you select *Other*, identify with whom you discussed the care plan.

Summary of Impairment:

Is homebound Physical Therapy reasonable and necessary?

☐ Yes ☐ No

Rationale:

Discussed Careplan with Patient?

☐ Yes ☐ No ☐ Other

Evaluation Findings & Plan of Care

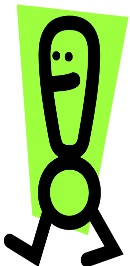
☐ Physician notified of evaluation findings and plan of care. ☐ By Phone ☐ By Fax

☐ Plan of care to follow standing physician orders.

☐ See initial agency POT/485 for therapy plan of care

☐ Informed patient/caregiver of frequency/duration of visits

Total Number of Projected P.T. Visits: ____ *Next*



✪ Per the State Plan of Correction (2006), you must always discuss your treatment plan, frequency, and duration with the patient. This box should always be checked Yes.

✪ In the event that the patient does not comprehend, make sure to discuss with caregiver, and indicate this by checking *Other* and providing details in the text field below.

✪ Also document your intended frequency and duration in this text field. (e.g. Pt and CG agree to 2-3X/4 wks)

Evaluation Findings & Plan of Care: Check in the appropiate box.

Informed patient/caregiver of frequency/duration of visits*. This box should *always* be checked. Make sure to inform the patient and his/her caregiver of the projected frequency and duration of therapy.

Number of projected visits: Indicate how many total visits you plan on making. This includes the assessment visit.

24: CarePlan Problem, Goals & Interventions (4)

To use this form: 1) Select an Active Problem. Based upon this selection, 2) select Active Goals & Interventions. 3) Check 'Add Selected G/I' to populate the G/I Addressed This Visit text box. 4) Return to the Active Problem, select new Problem. 5) Select new G/I. 6) Re-check the 'Add Selected' box.

Active Problems:

03/07/2008, Other (PT) (PT102)

Active Goals:

☐ Add Selected Goals

Goals Addressed This Visit:

Active Interventions:

☐ Add Selected Intervention

Interventions Addressed This Visit

☐ Care Plan and Goals developed with patient participation.

Next

You must provide the intervention(s) addressed, as well as patient performance on each intervention. You must provide a skilled treatment for this to be a billable visit. Once the interventions are provided, you can give additional information in this field. For example, you might want to describe the exercises you did and how many repetitions. This is the skilled portion of your note and justifies the visit.

25: BHC Supervisory Visit (Therapy)

Provide PTA Name.

Schedule: Include what the frequency and duration is to continue being.

Indicate whether this is direct or indirect supervisory visit.

Check all appropriate boxes in this section.

Home Health Aide Name: [ ]
PTA Name: [ ]
OTA Name: [ ]
Agency: [▾]
Schedule: [ ]

☐ **Direct Supervision** ☐ **Indirect Supervision**

Review Assignment Sheet / Plan of Care with Pt/Caregiver

Yes	No	
☐	☐	Is the staff following the assignment sheet / plan of care?
☐	☐	Is the staff courteous / respectful of property?
☐	☐	Is the patient satisfied with the care provided?
☐	☐	Does the staff arrive as scheduled?
☐	☐	Were any additional instructions given to the staff?
☐	☐	Does a change need to be made to the assignment sheet / Plan of Care?

Comment: [ ]

Next

In the comments section, include details of the suprevisory visit. For example: PT & PTA discussed upgrading HEP to include advancing theraband from yellow to red. Re-wrote HEP to include theraband for arc quads x10 reps and hip flexion. Pt required mod assist for return demo.

26: BHC Visit Narrative – Therapy (2) 1

Provide the date of your **Next Visit Date.**

Plan*: Enter your plan for this patient for the next visit.

This is a required field and **must** include the skill you will provide during your next visit. This information is intended to be used by another professional to plan a visit in the event of your absence.

Phone Call Made To: Per the State Plan of Correction (2006), following the assessment, you must contact the physician with your findings and the plan of care to be initiated.**

Circle one of one of the following:

- Case Manager
- DME
- Family Member
- Intake
- Other
- Patient/Caregiver
- Pharmacy
- Physician

Next Visit Date: __/__/____
Plan:
Phone Call Made To:
Details:
Visit Narrative:
Review of In Home Log
Reviewed In Home Log No Change to POC
Reviewed In Home Log - Based on findings of today's assessment, changes made to:
POC Freq/Dur Meds Other
Notes:
Medicare Generic Notice Provided & Reviewed
Signature Obtained / Declined:
Ongoing Discharge Planning with: Patient Family Caregiver
Discharge Planning Details:
This visit was NOT a Discharge. Check this box to Clear & Disable the following D/C forms. UNcheck to re-enable the forms. Next

Document the phone call in **Details** field. (If you make more than one call, you can document in the details field.)

** When contacting the Physician, make sure you indicate in the details field which office you called and with whom you spoke. For example:

Some exceptions to this requirement are:

- Evaluations completed the same day as the agency SOC
  - In this case, enter something like: *"See 485 for initial POC"*
- Therapy-only Oasis SOC visits
  - In this case, enter something like: *"See 485 for initial POC"*
- If you are following standing physician orders, please note this in the **visit narrative** field, in lieu of calling the physician.
  - In this case, enter something like: "*POC per Dr. Green TKA standing orders.*"

Visit Narrative: Enter any other subjective information about your visit here. To demonstrate interdisciplinary communication, document that you have reviewed the patient's chart. For example: *PT assessment reviewed/noted.*

Review of In Home Log*: Select one of the options. If you select changes, you will need to click on what was changed and then enter details in the **Notes** field. This field is intended to demonstrate interdisciplinary communication.

Medicare Generic Notice Provided & Reviewed: Medicare requires that agency provides information to patient/family regarding discharge appeal process. Check this box if the Medicare Generic Notice was given to and reviewed with the patient at the visit.

If you check this box, the **Signature Obtained/Declined** field will open up. Circle one of these four options. This is a required field.

1. Patient Signed
2. Representative Signed
3. Patient Refused to Sign
4. Representative Refused to Sign

Ongoing Dicharge Planning with: Check one or more of the fields – *Patient, Family, and/or Caregiver.*

Discharge Planning Details: You can provide additional information regarding the planned d/c in this field.

The D/C box. If you are planning on continuing to see this patient, check this box.

If this is your discharge visit, leave this box un-checked and you will need to fill out a separate discipline discharge form.

If this is your discharge visit, you will need to fill out a separate discipline discharge form.

Patient Initials: ________

Therapist Initials: _____

Visit Date: ________

Summary of Impairment:

As Evidenced By:	**PT PLAN / INTERVENTIONS**
☐ Gait disturbance	☐ Progressive gait training
☐ Decreased transfer skills	☐ Transfer Training
☐ Decreased bed mobility	☐ Bed mobility training
☐ LE strength deficit - B L R	☐ LE Therapeutic exercises
☐ LE ROM deficit - B L R	☐ LE ROM
☐ Decreased sitting balance	☐ Balance Training
☐ Decreased standing balance	☐ Stair climbing training
☐ Stair climbing deficit	☐ NMR (neuromuscular re-education)
☐ Decreased functional mobility	☐ Modalities ______________________________
☐ Pain (specify location) ____________________	☐ CPM
☐ Safety awareness	☐ D/C Planning
☐ Alteration in Cardiac Status	☐ Pt/ caregiver education and/or FMP
	☐ Safety instruction
☐ Care Path: Cardiac Rehab Phase 1 – Post Bypass or Infarction	☐ Cardiac Rehab Protocol
	☐ Measure BP & HR before and after therapy session
☐ Care Path: CHF - Moderate	☐ Notify MD if HR.150, and <60 after resting 5 minutes.
☐ Care Path: CHF Severe	☐ Notify MD if BP> 160/90, <90/50 after resting 5 minutes
☐ Care Path: CVA	
☐ Care Path: TKA	
☐ Care Path: THA	If **any** care path is chosen, you **must** select this intervention: ☐ **Implement (Specific) Care Path per Agency protocol
☐ Other __________________________________	☐ Other _________________________________

Frequency: _____ X's per week for _____ Weeks

Discussed care plan with patient: ☐ Yes ☐ No

Physical Therapist Signature: ____ Date: _____________

SHORT TERM GOALS

□ Gait: I SBA CG MIN MOD MAX ______ feet with ______ device for household / community distances.

□ Increase transfers for increased ability to change position in his/ her environment.

□ Sit to Stand I SBA CG MIN MOD MAX

□ Stand to sit I SBA CG MIN MOD MAX

□ Sit to chair I SBA CG MIN MOD MAX

□ Bed mobility: I SBA CG MIN MOD MAX for increased ability to move self in/out of bed.

□ Increase strength from /5 to /5 to stabilize gait and improve functional mobility.

□ Increase ROM from _______° to ________° for comfort with sitting , normalize gait and obstacle avoidance.

□ Increase dynamic sitting balance from G F P to G F P to improve postural alignment.

□ Increase dynamic standing balance from G F P to G F P for safety with transfers and gait

□ Increase stair climbing from _____ steps to _____ steps

□ Pt / caregiver demonstrates proficiency in HEP

□ Decrease pain from ________ to ________

LONG TERM GOALS

□ Gait: I SBA CG MIN MOD MAX ______ feet with ______ device for household / community distances.

□ Increase transfers for increased ability to change position in his/ her environment.

□ Sit to Stand I SBA CG MIN MOD MAX

□ Stand to sit I SBA CG MIN MOD MAX

□ Sit to chair I SBA CG MIN MOD MAX

□ Bed mobility: I SBA CG MIN MOD MAX for increased ability to move self in/out of bed.

□ Increase strength from /5 to /5 to stabilize gait and improve functional mobility.

□ Increase ROM from _______° to ________° for comfort with sitting , normalize gait andobstacle avoidance.

□ Increase dynamic sitting balance from G F P to G F P to improve postural alignment.

□ Increase dynamic standing balance from G F P to G F P for safety with transfers and gait

□ Increase stair climbing from _____ steps to _____ steps

□ Pt / caregiver demonstrates proficiency in HEP

□ Decrease pain to a manageable level

□ Pt's VS will remain stable before and after therapy sessions.

□ PT will nofity MD if VS are outstide of parameters

If **any** care path is chosen, you **must** select this goal:
□ **Pt will achieve outcomes per established Care Path