**PHYSICAL THERAPY CARE PLAN**

**INTERVENTIONS**

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Balance training/activities</th>
<th>Teach hip safety precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish/upgrade home exercise program</td>
<td>Pulmonary Physical Therapy</td>
<td>Teach safe/effective use of adaptive/assist device (specify)</td>
</tr>
<tr>
<td>Copy given to patient</td>
<td>Ultrasound to _____ at _____ x _____ min</td>
<td>Electrotherapy to _____ for _____ min</td>
</tr>
<tr>
<td>Copy attached to chart</td>
<td></td>
<td>Teach safe stair climbing skills</td>
</tr>
</tbody>
</table>

**Additional Specific Therapy Goals**

<table>
<thead>
<tr>
<th>Patient Expectation</th>
<th>SHORT TERM</th>
<th>LONG TERM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time Frame</td>
<td>Time Frame</td>
</tr>
</tbody>
</table>

**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.
- Pt. will be able to climb stair/uneven surface with/without assistance steps # _____ within _____ weeks.

**MUSCLE STRENGTH**
- Pt. will be able to hold weight _____ 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.
- Pain will decrease from _____/10 to _____/10 within _____ weeks.

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

**SAFETY**
- Pt. will be able to use _____ with/without assistance _____ feet within _____ weeks.
- Pt. will be able to propel wheelchair _____ feet within _____ weeks.
- HEP will be established and initiated.

**ADDITIOnAL SPECIFIC THERAPY 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 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.
- Pt. will be able to climb stair/uneven surface with/without assistance steps # _____ within _____ weeks.

**MUSCLE STRENGTH**
- Pt. will be able to hold weight _____ 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.
- Pain will decrease from _____/10 to _____/10 within _____ weeks.

**ROM**
- Pt. will increase ROM of _____ by _____ degrees flexion/extension within _____ weeks.
- 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 wheelchair _____ feet within _____ weeks.
- Pt. will be able to finalize and demonstrated to follow up HEP.

**DISCHARGE PLANS DISCUSSED WITH:**
- Patient/Family
- Care Manager
- Physician
- Other (specify)  

**CARE COORDINATION:**
- Physician
- OT
- SN
- ST
- MSW
- Aide
- PTA
- Other (specify)

**REHAB POTENTIAL:**
- Poor
- Fair
- Good
- Excellent

**Equipment needed:**

**Patient/Caregiver aware and agreeable to POC:**
- Yes
- No (explain):

**Plan developed by:**

**Therapist Name/Signature/title**

**Diagnosis/Reason for PT:**

**Physician signature:**

**APPROXIMATE NEXT VISIT DATE:**

**PLAN FOR NEXT VISIT**

**Original - Patient Chart**

**Copy - Patient's Home Chart**
OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

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

TYPE OF EVALUATION  
- Initial  
- Interim  
- Final  

SOC DATE  
- Initial Evaluation  
- 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

MEDICAL HISTORY

- Hypertension
- Cardiac
- Diabetes
- Respiratory
- Osteoporosis
- Other (specify)

MEDICAL PRECAUTIONS:

- 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):

VITAL SIGNS/CURRENT STATUS

- BP: __________________________________________ T.P.R.: ___________________________ Sensation: ____________________________
- Skin Condition: ____________________________ Muscle Tone: ____________________________
- Communication: __________________________ Vision: __________________________
- Endurance: ____________________________ Orthotic/ Prosthetic Devices: ____________________________

PHYSICAL THERAPY EVALUATION  
- EVALUATION  
- RE-EVALUATION

DATE OF SERVICE ________ / ________ / ________

TIME IN ________ OUT ________

PART 1 — Clinical Record  
PART 2 — Therapist

PATIENT/CLIENT NAME - Last First, Middle Initial  
ID#
### PHYSICAL THERAPY (Cont'd.)

#### MUSCLE STRENGTH/FUNCTIONAL ROM EVAL

<table>
<thead>
<tr>
<th>AREA</th>
<th>ACTION [Right]</th>
<th>ROM [Right]</th>
<th>ACTION [Left]</th>
<th>ROM [Left]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder</td>
<td>Flex/Extend</td>
<td></td>
<td>Abd./Add.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Int. rot./Ext. rot.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow</td>
<td>Flex/Extend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forearm</td>
<td>Sup./Pron.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist</td>
<td>Flex/Extend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fingers</td>
<td>Flex/Extend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td>Flex/Extend</td>
<td></td>
<td>Abd./Add.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Int. rot./Ext. rot.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td>Flex/Extend</td>
<td></td>
<td>Plant/Dors</td>
<td></td>
</tr>
<tr>
<td>Ankle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot</td>
<td>Inver/Ever</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### FUNCTIONAL INDEPENDENCE/BALANCE EVAL

<table>
<thead>
<tr>
<th>TASK</th>
<th>ASSIST SCORE</th>
<th>ASSISTIVE DEVICES/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roll/Turn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sit/Supine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scoot/Bridge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sit/Stand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed/Wheelchair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Floor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auto</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static Sitting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dynamic Sitting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dynamic Standing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propulsion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure Relief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot Rests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### OBJECTIVE DATA TESTS AND SCALES

### MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Normal functional strength - against gravity - full resistance.</td>
</tr>
<tr>
<td>4</td>
<td>Good strength - against gravity with some resistance.</td>
</tr>
<tr>
<td>3</td>
<td>Fair strength - against gravity - no resistance - safety compromised.</td>
</tr>
<tr>
<td>2</td>
<td>Poor strength - unable to move against gravity.</td>
</tr>
<tr>
<td>1</td>
<td>Trace strength - slight muscle contraction - no motion.</td>
</tr>
<tr>
<td>0</td>
<td>Zero - no active muscle contraction.</td>
</tr>
</tbody>
</table>

### FUNCTIONAL RANGE OF MOTION (ROM) SCALE

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>106% active functional motion.</td>
</tr>
<tr>
<td>4</td>
<td>75% active functional motion.</td>
</tr>
<tr>
<td>3</td>
<td>50% active functional motion.</td>
</tr>
<tr>
<td>2</td>
<td>25% active functional motion.</td>
</tr>
<tr>
<td>1</td>
<td>Less than 25%.</td>
</tr>
</tbody>
</table>

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

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

### BALANCE SCALE (sitting - standing)

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Independent</td>
</tr>
<tr>
<td>4</td>
<td>Verbal cue (VC) only needed.</td>
</tr>
<tr>
<td>3</td>
<td>Stand-by assist (SBA)-100% patient/client effort.</td>
</tr>
<tr>
<td>2</td>
<td>Minimum assist (Min A)-75% patient/client effort.</td>
</tr>
<tr>
<td>1</td>
<td>Maximum assist (Max A)- 50% patient/client effort.</td>
</tr>
<tr>
<td>0</td>
<td>Totally dependent for support.</td>
</tr>
</tbody>
</table>

### GAIT

<table>
<thead>
<tr>
<th>SURFACES</th>
<th>Level</th>
<th>Uneven</th>
<th>Stairs (number/condition)</th>
<th>DISTANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEIGHT BEARING STATUS</td>
<td>FWB</td>
<td>WBAT</td>
<td>PWB</td>
<td>TDWB</td>
</tr>
<tr>
<td>ASSISTIVE DEVICE(S)</td>
<td>Cane</td>
<td>Quad cane</td>
<td>Crutches</td>
<td>Hemi-walker</td>
</tr>
<tr>
<td>Wheeled walker</td>
<td>Walker</td>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FOR RE-EVALUATION USE ONLY:

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

- [ ] CHANGE
- [ ] NOT CHANGE

### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>PATIENT’S NAME:</th>
<th>MED. RECORD #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>THERAPIST'S SIGNATURE/TITLE</th>
<th>DATE / /</th>
<th>PHYSICIAN'S SIGNATURE</th>
<th>DATE / /</th>
</tr>
</thead>
</table>

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

### MENTAL STATUS:
- [ ] Oriented
- [ ] Forgetful
- [ ] Disoriented
- [ ] Agitated
- [ ] Comatose
- [ ] Depressed
- [ ] Lethargic
- [ ] Other

### HOMEBOUND STATUS DUE TO:
- [ ] Bed bound
- [ ] Severe SOB
- [ ] Up in Chair with max assist
- [ ] Ambulates with Assist
- [ ] Uses W/C, Walker, Cane
- [ ] 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)

<table>
<thead>
<tr>
<th></th>
<th>Pt.</th>
<th>C.G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic Exercises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adaptive Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gait Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS, Ultrasound, Massages, Hot/Cold Pack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy Conservation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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


Date/Describe:

Next Scheduled Visit Date: ___________________________ Plan for Next Visit: ___________________________

Additions to Plan of Care

Patient Name ___________________________ Date: ___________________________

Therapist Name/Signature/Title ___________________________
PHYSICAL THERAPY REVISIT NOTE

VITAL SIGNS: Temperature: ___________ Pulse: ___________ Regular □ Irregular □ Regular □ Irregular
Blood Pressure: Right / Left / □ Regular □ Irregular □ Regular □ Irregular
Pain: □ None □ Same □ Improved □ Worse □ Other (specify)
Duration: □ Location(s)

HOMEBOUND REASON: □ 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)

TREATMENT DIAGNOSIS/PROBLEM AND EXPECTED OUTCOMES:

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

<table>
<thead>
<tr>
<th>Modality used</th>
<th>Location</th>
<th>Frequency</th>
<th>Duration</th>
<th>Intensity</th>
<th>Other</th>
</tr>
</thead>
</table>

SAFETY ISSUES

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

TEACHING, TRAINING, RESPONSE TO INSTRUCTIONS:

PATIENT/FAMILY RESPONSE TO INSTRUCTIONS:

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

Complete TIME OUT prior to signing below.

PART 1 - Clinical Record

PART 2 - Therapist
**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) ____________________________________________________________

**ID#**

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

**TYPE OF EVALUATION**
- ☐ 13TH VISIT ☐ Supervisory
- ☐ 19TH VISIT ☐ 30 day visit
- ☐ Other visit:
  - Indicate # ______

**SOC Date** ______/_____/_____

**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
- ☐ Steps (number/condition) ______
- ☐ Other (specify) __________________________________________

**BEHAVIOR/MENTAL STATUS**

- ☐ Alert
- ☐ Oriented
- ☐ Cooperative
- ☐ Confused
- ☐ Memory deficits
- ☐ Impaired judgment
- ☐ Other (specify) __________________________________________

**CURRENT PAIN**

**Location(s)**

**Pain (describe)**

**Impact on Function**

**Previous Pain Level**

**CURRENT ADL/ IADLs**

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

PATIENT/ CLIENT NAME - Last, First, Middle Initial

ID#
**MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH**

<table>
<thead>
<tr>
<th>GRADE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Normal functional strength - against gravity - full resistance.</td>
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<td>Fair strength - against gravity - no resistance – safety compromise.</td>
</tr>
<tr>
<td>2</td>
<td>Poor strength - unable to move against gravity.</td>
</tr>
<tr>
<td>1</td>
<td>Trace strength - slight muscle contraction - no motion.</td>
</tr>
</tbody>
</table>

**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)

**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**

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

**Current Goals that pertain to current illness**

- Pt. will ______ assist with bed mobility within______ weeks or visits.
- Pt. to demonstrate increased strength of _______ (include specific joint, muscle, and indicate left, right or bilat.) to ______ within ______ weeks or visits.
- Pt. &/or cg will demonstrate comprehension of home exercise program within ______ weeks or visits.
- Pt will verbalize pain relief from ___/10 to ____/10 within ______ weeks or visits.
- Pt. will demonstrate increased ___ ROM of ______ to ______ degrees within ______ weeks or visits.
- Pt/cg will demonstrate ______ transfers with level of assist within ______ weeks or visits.
- Pt will ambulate ______ feet with ______ assistance or ______ without assistive device within ______ weeks or visits.
- Increase ______ sitting balance to ______ within ______ weeks or visits.
- Increase ______ standing balance to ______ within ______ weeks or visits.

**Additional Current 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
**VITAL SIGNS:**
- Pulse: __________
- Respiration: __________
- Blood Pressure: Right / / Left / /

**PAIN:**
- Location(s): __________
- Frequency: __________
- Relief Measures: __________

**HOMEBOUND REASON:**
- Needs assistance for all activities
- Requires assistance to ambulate
- Requires assistance to transfer
- Unable to safely leave home unassisted
- Dependant upon adaptive device(s)

**TREATMENT DIAGNOSIS/PROBLEM**

**INTERRUPTIONS**
- Evaluation
- Establish rehab. program
- Establish home exercise program
- Patient/Client/Family education
- Therapeutic/Isometric/Isotonic Exercises
- Muscle Strengthening
- Passive/Active/Resistive exercises
- Stretching exercises
- Transfer Training
- Balance training/activities

**SAFETY ISSUES**
- Obstructive pathways
- Home environment
- Stairs
- Unsteady gait
- Verbal cues required
- Equipment in poor condition
- Bathroom
- Impaired judgement/safety
- Other

**ASSESSMENT/PROGRESS TOWARDS GOALS:**
- ROM:
- STRENGTH:
- BALANCE:
- AMBULATION:
- TRANSFERS/Bed MOBILITY:
- PATIENT/CAREGIVER RESPONSE:

**PLAN FOR NEXT VISIT:**

**DISCHARGE PLANS DISCUSSED WITH:**
- Patient/Family/Caregiver
- Care Manager
- Physician
- Other

**CARE COORDINATION:**
- None
- Physician
- PT/PTA
- OT
- SLP
- MSW
- SN
- HHA
- Case Manager
- Other

**SIGNATURE/DATE:**
- Therapist (signature/title)
- Date

**PATIENT NAME - Last, First, Middle Initial**

**MEDICATION CHANGE:**
- Since last visit: Yes / No
### PHYSICAL THERAPY EVALUATION

**DATE OF SERVICE _____ / _____ / _____**

**SOC DATE _____ / _____ / _____**

**OTHER DISCIPLINES PROVIDING CARE:**
- SN
- OT
- ST
- MSW
- Aide

**PHYSICAL THERAPY EVALUATION**

- **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
  - Requires assistance to transfer
  - Medical restrictions
  - Other (specify) ____________
  - Dependent upon adaptive device(s)

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

**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 ______
- Intermittent
- Continuous
- Cooperative
- Confused
- Memory deficits
- Impaired judgement
- Other (specify) ____________

**TRANSFER MOBILITY:**

- Independent
- Level of assistance ____________
- Unable
- Other: ____________

**COMMUNITY MOBILITY (gait or wheelchair/scooter):**

- Independent
- Level of assistance ____________
- Unable
- Other: ____________

**VITAL SIGNS/CURRENT STATUS**

- Blood Pressure: ________ / ________
- Pulse: ____________
- Respiration: ____________
- Skin Condition: ____________
- Edema: ____________
- Vision: ____________
- Sensation: ____________
- Communication: ____________
- Hearing: ____________
- Posture: ____________
- Activity Tolerance: ____________

**OTHER DISCIPLINES PROVIDING CARE:**

- SN
- OT
- ST
- MSW
- Aide

**PAIN**

- Location: ____________
- Frequency: Occasional
- Intermittent
- Continuous

**AGGRAVATING/RELIEVING FACTORS:**

- ____________
- ____________
- ____________
- ____________

**LOCATION:**

- ____________

**PATIENT NAME - Last, First, Middle Initial**

**ID#**

- ____________

[Continued on Next Page]
### PHYSICAL THERAPY EVALUATION (Cont’d)

#### STRENGTH

<table>
<thead>
<tr>
<th>AREA</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder</td>
<td>Flex/Extend</td>
<td>Flex/Extend</td>
</tr>
<tr>
<td></td>
<td>Abd/Add.</td>
<td>Abd/Add.</td>
</tr>
<tr>
<td>Elbow</td>
<td>Flex/Extend</td>
<td>Flex/Extend</td>
</tr>
<tr>
<td>Forearm</td>
<td>Sup./Pron.</td>
<td>Sup./Pron.</td>
</tr>
<tr>
<td>Wrist</td>
<td>Flex/Extend</td>
<td>Flex/Extend</td>
</tr>
<tr>
<td>Fingers</td>
<td>Flex/Extend</td>
<td>Flex/Extend</td>
</tr>
<tr>
<td></td>
<td>Abd./Add.</td>
<td>Abd./Add.</td>
</tr>
<tr>
<td>Hip</td>
<td>Flex/Extend</td>
<td>Flex/Extend</td>
</tr>
<tr>
<td>Knee</td>
<td>Flex/Extend</td>
<td>Flex/Extend</td>
</tr>
<tr>
<td>Ankle</td>
<td>Plant./Dors.</td>
<td>Plant./Dors.</td>
</tr>
<tr>
<td>Foot</td>
<td>Inver./Ever.</td>
<td>Inver./Ever.</td>
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</table>

#### UPPER EXTREM.

<table>
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<th>STRENGTH</th>
<th>ACTION</th>
<th>ROM</th>
</tr>
</thead>
<tbody>
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<td>Bed/Wheelchair</td>
<td>Sit/Supine</td>
<td>Scoot/Bridge</td>
</tr>
<tr>
<td>Sit/Stand</td>
<td>Toile</td>
<td>Floor</td>
<td>Auto</td>
</tr>
<tr>
<td>Scoot/Bridge</td>
<td>Static Sitting</td>
<td>Dynamic Sitting</td>
<td>Static Standing</td>
</tr>
<tr>
<td>Sit/Stand</td>
<td>Dynamic Standing</td>
<td>Propulsion</td>
<td>Pressure Reliefs</td>
</tr>
<tr>
<td>Bed/Wheelchair</td>
<td>Foot Rests</td>
<td>Locks</td>
<td></td>
</tr>
</tbody>
</table>

#### LOWER EXTREM.

<table>
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<tr>
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<td>Inver./Ever.</td>
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</table>

#### SPINE

<table>
<thead>
<tr>
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<th>ROM</th>
</tr>
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<td>Static Standing</td>
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#### MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

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<td>Normal functional strength - against gravity - full resistance</td>
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<td>4</td>
<td>Good strength - against gravity with some resistance</td>
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<tr>
<td>3</td>
<td>Fair strength - against gravity - no resistance - safety compromise</td>
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<tr>
<td>2</td>
<td>Poor strength - unable to move against gravity</td>
</tr>
<tr>
<td>1</td>
<td>Trace strength - slight muscle contraction - no motion</td>
</tr>
<tr>
<td>0</td>
<td>Zero - no active muscle contraction</td>
</tr>
</tbody>
</table>

#### FUNCTIONAL RANGE OF MOTION (ROM) SCALE

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>100% active functional motion</td>
</tr>
<tr>
<td>4</td>
<td>75% active functional motion</td>
</tr>
<tr>
<td>3</td>
<td>50% active functional motion</td>
</tr>
<tr>
<td>2</td>
<td>25% active functional motion</td>
</tr>
<tr>
<td>1</td>
<td>Less than 25%</td>
</tr>
</tbody>
</table>

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

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

#### SAFETY ISSUES

- Obstructive pathways
- Equipment in poor condition
- Home environment
- Bathroom
- Impaired judgment/safety
- Other (specify)
- Verbal cues required

#### GAIT

- Independent
- SBA
- Contact guard
- Minimum assist
- Moderate assist
- Maximum assist
- Unable

- Level
- Uneven
- Stairs (number/condition)

- FWB
- WBAT
- PWB
- TTWB
- NWB

- Cane
- Quad Cane
- Crutches
- Hemi Walker
- Walker
- Wheeled Walker

- Other (specify)

#### QUALITY/DEVIATIONS/POSTURES:

- Summary

#### 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

- Therapist Printed Name and Title
- 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**

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

**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 RL UE to ____/5 in ____ weeks
- Increase strength of RL 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 RL UE to ____/5 in ____ weeks
- Increase strength of RL 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**

- Pulse
- Blood Pressure
- Respiration

**Monitor Vital Signs:**

- U.S. to ________ at ________ warts/cm2 x ________ minutes.
- EMS to ________ x ________ minutes.
- Heat/Cold to ________ x ________ minutes.
- Therapeutic massage to ________ x ________ minutes.
- Joint Mobilization ________

**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
### THERAPY DISCHARGE SUMMARY

**Patient Information**
- **Last Name:**
- **First Name:**
- **Patient #:**

**Type of Discharge:**
- [ ] Complete
- [ ] Partial - Still Receiving Services Of:
  - [ ] PT
  - [ ] ST
  - [ ] OT
  - [ ] HHA
  - [ ] SN

**Admission Date:**

**Discharge Date:**

**Reason for Discharge:**
- [ ] 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:**
- [ ] Independent
- [ ] Requires Supervision/Assist

**Exercises Performed With:**
- [ ] Passive
- [ ] Active
- [ ] Active Assistive
- [ ] Resistive

**Transfer:**
- [ ] Hoyer Lift
- [ ] Walker

**Activities:**
- [ ] W/C
- [ ] Quad Cane
- [ ] Other

**Gait Training:**
- [ ] N.W.B.
- [ ] P.W.B.
- [ ] F.W.B.

**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
- Demonstrates transfer technique and use of special devices
- Demonstrates ability to do special treatments
- 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
- Demonstrates knowledge of operation & care of adaptive equipment
- Demonstrates energy conservation/work simplification techniques
- Demonstrations compensatory & safety techniques

**Occupational Therapy**
- Patient has attained maximum benefit from therapeutic program
- Demonstrates dressing techniques
- Describes phantom limb sensation
- Demonstrates stabilization of ambulation

**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:**

**Therapist Signature:**

**Date:**

**White:** Medical Records  **Yellow:** Physician
### 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:

<table>
<thead>
<tr>
<th>Admission Status</th>
<th>Discharge Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain due to ______, level ______</td>
<td>Pain due to ______, level ______</td>
</tr>
<tr>
<td>ROM ____________</td>
<td>ROM ____________</td>
</tr>
<tr>
<td>Strength and Endurance ______</td>
<td>Str/End ______</td>
</tr>
<tr>
<td>Balance ________</td>
<td>Balance ________</td>
</tr>
<tr>
<td>Coordination ______</td>
<td>Coordination ______</td>
</tr>
<tr>
<td>Bed Mobility ______</td>
<td>Bed Mobility ______</td>
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<tr>
<td>Transfers ______</td>
<td>Transfers ______</td>
</tr>
<tr>
<td>Ambulation ______</td>
<td>Ambulation ______</td>
</tr>
<tr>
<td>Fine Motor Coordination ______</td>
<td>Fine Motor Coord ______</td>
</tr>
<tr>
<td>Sensory/Perceptual Awareness ______</td>
<td>S/P Awareness ______</td>
</tr>
<tr>
<td>Sensory/Perceptual Coordination ______</td>
<td>S/P Coord ______</td>
</tr>
<tr>
<td>Receptive Communication ______</td>
<td>Receptive Com ______</td>
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<tr>
<td>Expressive Communication ______</td>
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<tr>
<td>Swallowing ______</td>
<td>Swallowing ______</td>
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<tr>
<td>Knowledge level of Disease Process ______</td>
<td>Knowledge level of Disease Process ______</td>
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<td>HEP ______</td>
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<tr>
<td>Treatments ______</td>
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<tr>
<td>Care Management ______</td>
<td>Care Management ______</td>
</tr>
<tr>
<td>Safety ______</td>
<td>Safety ______</td>
</tr>
<tr>
<td>Other ______</td>
<td>Other ______</td>
</tr>
<tr>
<td>Other ______</td>
<td>Other ______</td>
</tr>
</tbody>
</table>

### 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**

### Additional Specific Therapy Goals Reached

<table>
<thead>
<tr>
<th>Patient Expectation</th>
<th>Short Term</th>
<th>Long Term</th>
</tr>
</thead>
</table>

**Discharge Instructions Discussed With:**
- Patient/Family
- Care Manager
- Physician
- Other (specify) __________

**Care Was Coordinated:**
- Physician
- OT
- SN
- ST
- MSW
- Aide
- PTA
- Other (specify) __________

**Rehab Status:**
- Poor
- Fair
- Good
- Excellent

**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 __________.**

**Discharged: Maximum Functional Potential Reached. Able to understand medication regimen and care related to disease.**

**Goals Documented by:** __________________________

**Therapist Name/Signature/title:** __________________________

**Patient Name - Last, First, Middle Initial:** __________________________

**ID #:** __________________________