



# PHYSICAL THERAPY CARE PLAN

Diagnosis/ Reason for OT: \_\_\_\_\_ ONSET: \_\_\_\_\_  
 Frequency and Duration: \_\_\_\_\_

INTERVENTIONS			Locator #21
Evaluation	Balance training /activities	Teach hip safety precautions	
Establish/ upgrade home exercise program <input type="checkbox"/> Copy given to patient <input type="checkbox"/> 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	

Note: Each modality specify frequency, duration, amount and specify location: \_\_\_\_\_

SHORT TERM GOALS	LONG TERM GOALS	Locator #22
<p><b>GENERAL</b></p> <p><input type="checkbox"/> Gait will increase tinetti gait score to _____ / 12 within _____ weeks.</p> <p><input type="checkbox"/> Will improve gait requiring _____ to _____ from _____ to _____ within _____ weeks.</p> <p><b>BED MOBILITY</b></p> <p><input type="checkbox"/> Pt. will be able to turn side (facing up) to lateral (left/right) within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to butt scoot within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to sit up with/without assistance _____ within _____ weeks.</p> <p><b>BALANCE</b></p> <p><input type="checkbox"/> Will increase tinetti balance score to _____/16 within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to reach steady static/dynamic sitting/standing balance with/without assistance _____ within _____ weeks</p> <p><b>TRANSFER</b></p> <p><input type="checkbox"/> Pt. will be able to transfer from _____ to _____ with/without assistance _____ within _____ weeks.</p> <p><b>STAIR/UNEVEN SURFACE</b></p> <p><input type="checkbox"/> Pt. will be able to climb stair/uneven surface with/without assistance _____ steps # _____ within _____ weeks.</p> <p><b>MUSCLE STRENGTH</b></p> <p><input type="checkbox"/> Pt. will be able to hold weigh _____ lb within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to oppose flexion or extension force over _____ within _____ weeks.</p> <p><b>PAIN</b></p> <p><input type="checkbox"/> Pain will decrease from _____/10 to _____/10 within _____ weeks.</p> <p><b>ROM</b></p> <p><input type="checkbox"/> Pt. will increase ROM of _____ by _____ degrees flexion/extension within _____ weeks.</p> <p><b>SAFETY</b></p> <p><input type="checkbox"/> Pt. will be able to use _____ with/without assistance to _____ feet within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to propel wheel chair _____ feet within _____ weeks.</p> <p><input type="checkbox"/> HEP will be established and initiated.</p>	<p><b>GENERAL</b></p> <p><input type="checkbox"/> Gait will increase tinetti gait score to _____ / 12 within _____ weeks.</p> <p><input type="checkbox"/> Will improve gait requiring _____ to _____ from _____ to _____ within _____ weeks.</p> <p><b>BED MOBILITY</b></p> <p><input type="checkbox"/> Pt. will be able to turn side (facing up) to lateral (left/right) within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to lie back down within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to sit up independently _____ within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to self reposition within _____ weeks.</p> <p><b>BALANCE</b></p> <p><input type="checkbox"/> Will increase tinetti balance score to _____/16 within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to reach steady static/dynamic sitting/standing balance with/without assistance _____ within _____ weeks</p> <p><b>TRANSFER</b></p> <p><input type="checkbox"/> Pt. will be able to transfer from _____ to _____ with/without assistance _____ within _____ weeks.</p> <p><b>STAIR/UNEVEN SURFACE</b></p> <p><input type="checkbox"/> Pt. will be able to climb stair/uneven surface with/without assistance _____ steps # _____ within _____ weeks.</p> <p><b>MUSCLE STRENGTH</b></p> <p><input type="checkbox"/> Pt. will be able to hold weigh _____ lb within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to oppose flexion or extension force over _____ within _____ weeks.</p> <p><b>PAIN</b></p> <p><input type="checkbox"/> Pain will decrease from _____/10 to _____/10 within _____ weeks.</p> <p><b>ROM</b></p> <p><input type="checkbox"/> Pt. will increase ROM of _____ by _____ degrees flexion/extension within _____ weeks.</p> <p><b>SAFETY</b></p> <p><input type="checkbox"/> Pt. will be able to use _____ independently to _____ feet within _____ weeks.</p> <p><input type="checkbox"/> Pt. will be able to self propel wheel chair _____ feet within _____ weeks.</p> <p><input type="checkbox"/> Pt will be able to finalize and demonstrated to follow up HEP.</p>	

### 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

Original - Physician Copy - Clinical Record (until signed original returned)

PATIENT NAME - Last, First, Middle Initial ID#



**PHYSICAL THERAPY**

EVALUATION     RE-EVALUATION

DATE OF SERVICE      /      /     

TIME IN      OUT     

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

<b>HOMEBOUND REASON:</b> <input type="checkbox"/> Needs assistance for all activities <input type="checkbox"/> Residual weakness <input type="checkbox"/> Requires assistance to ambulate <input type="checkbox"/> Confusion, unable to go out of home alone <input type="checkbox"/> Unable to safely leave home unassisted <input type="checkbox"/> Severe SOB, SOB upon exertion <input type="checkbox"/> Dependent upon adaptive device(s) <input type="checkbox"/> Medical restrictions <input type="checkbox"/> Other (specify) _____	<b>TYPE OF EVALUATION</b> <input type="checkbox"/> Initial <input checked="" type="checkbox"/> Interim <input type="checkbox"/> Final <b>SOC DATE</b> <u>    </u> / <u>    </u> / <u>    </u> (if Initial Evaluation, complete Physical Therapy Care Plan)
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**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	PRIOR/CURRENT LEVEL OF FUNCTION
<input type="checkbox"/> Hypertension <input type="checkbox"/> Fractures                      Assistive Device: <input type="checkbox"/> Cardiac <input type="checkbox"/> Cancer                        Needs: <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection                      _____ <input type="checkbox"/> Respiratory <input type="checkbox"/> Immunosuppressed        _____ <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Open wound                  Has: <input type="checkbox"/> Other (specify) _____ _____	Prior level of function (ADL/IADL) Specify: (ADL/IADL On Problematic Areas) _____ _____ _____ _____ Current level of function (ADL/IADL) Specify: (ADL/IADL On Problematic Areas) _____ _____ _____ _____

**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): \_\_\_\_\_

**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#



MUSCLE STRENGTH/FUNCTIONAL ROM EVAL						FUNCTIONAL INDEPENDENCE/BALANCE EVAL				
	AREA	STRENGTH		ACTION	ROM		TASK	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS	
		Right	Left		Right	Left				
UPPER EXTREMITIES	Shoulder			Flex/Extend			BED MOBILITY	Roll/Turn		
				Abd./Add.				Sit/Supine		
				Int. rot./Ext. rot.				Scoot/Bridge		
	Elbow	Forearm	Wrist	Fingers	Flex/Extend			TRANSFERS	Sit/Stand	
									Bed/Wheelchair	
									Toilet	
									Floor	
	LOWER EXTREMITIES	Hip			Flex/Extend			BALANCE	Static Sitting	
Dynamic Sitting										
Static Standing										
Knee		Ankle	Foot	Flex/Extend	Plant/Dors	Inver/Ever		W/C SKILLS	Dynamic Standing	
									Propulsion	
									Pressure Reliefs	
									Foot Rests	
									Locks	

**OBJECTIVE DATA TESTS AND SCALES**

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH		FUNCTIONAL RANGE OF MOTION (ROM) SCALE	
GRADE	DESCRIPTION	GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance.	5	106% active functional motion.
4	Good strength - against gravity with some resistance.	4	75% active functional motion.
3	Fair strength - against gravity - no resistance - safety compromise.	3	50% active functional motion.
2	Poor strength - unable to move against gravity.	2	25% active functional motion.
1	Trace strength - slight muscle contraction - no motion.	1	Less than 25%.
0	Zero - no active muscle contraction.		

FUNCTIONAL INDEPENDENCE SCALE (bed mobility, transfers, W/C skills)		NORMATIVE DATA FOR JOINT MOTION (ROM)				
GRADE	DESCRIPTION	AREA	ACTION/MOVEMENT			
5	Physically able and does task independently.	Shoulder	Flex	158°	Extend	55°
4	Verbal cue (VC) only needed.		Abd.	170°	Add.	50°
3	Stand-by assist (SBA)-100% patient/client effort.		Int. rot.	70°	Ext. rot.	90°
2	Minimum assist (Min A)-75% patient/client effort.	Elbow	Flex	145°	Ext.	0°
1	Maximum assist (Max A)-25% - 50% patient/client effort.		Forearm	Sup.	85°	Pron.
0	Totally dependent-total care/support	Wrist	Flex	73°	Ext.	70°
		Fingers	Flex all	90°	Ext.	0°

BALANCE SCALE (sitting - standing)							
GRADE	DESCRIPTION	AREA	ACTION/MOVEMENT				
5	Independent	Hip	Flex	901-115°	Ext.	25°	
4	Verbal cue (VC) only needed.		Abd.	45°	Add.	30°	
3	Stand-by assist (SBA)-100% patient/client effort.		Int. rot.	45°	Ext. rot.	45°	
2	Minimum assist (Min A)-75% patient/client effort.	Knee	Flex	135°	Ext.	10°	
1	Maximum assist (Max A)-25% patient/client effort.		Ankle	Plant.	50°	Dors.	20°
0	Totally dependent for support.		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.



## 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 \_\_\_\_\_

<b>HOMEBOUND STATUS DUE TO:</b>	<input type="checkbox"/> Bed bound	<input type="checkbox"/> Severe SOB	<input type="checkbox"/> Ambulates with Assist	<input type="checkbox"/> Uses W/C, Walker, Cane
	<input type="checkbox"/> Up in Chair with max assist	<input type="checkbox"/> Severe Weakness	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Unable to walk
	<input type="checkbox"/> Balance/Gait - Unsteady	<input type="checkbox"/> Other _____		

Subjective Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Specific Safety Issues Addressed: \_\_\_\_\_  
 \_\_\_\_\_

TREATMENT RENDERED (If Pt/CG. instructed. see response below)	INSTRUCTED:	Pt.	C.G
<input type="checkbox"/> Assessment _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Therapeutic Exercises _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adaptive Equipment _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Transfer Training _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gait Training _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> EMS, Ultrasound, Massages, Hot/Cold Pack _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Energy Conservation _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: \_\_\_\_\_



DATE OF SERVICE: \_\_\_\_\_

PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

TIME IN \_\_\_\_\_ OUT \_\_\_\_\_

**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 \_\_\_\_\_

<b>HOMEBOUND REASON:</b> <input type="checkbox"/> Needs assistance for all activities <input type="checkbox"/> Residual weakness <input type="checkbox"/> Requires assistance to ambulate <input type="checkbox"/> Confusion, unable to go out of home alone <input type="checkbox"/> Unable to safely leave home unassisted <input type="checkbox"/> Severe SOB, SOB upon exertion <input type="checkbox"/> Dependent upon adaptive device(s) <input type="checkbox"/> Medical restrictions <input type="checkbox"/> Other (specify) _____	<b>TYPE OF VISIT:</b> <input type="checkbox"/> Revisit <input type="checkbox"/> Revisit and Supervisory Visit <input type="checkbox"/> Other (specify) _____ SOC DATE: _____
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TREATMENT DIAGNOSIS/PROBLEM AND EXPECTED OUTCOMES: \_\_\_\_\_

**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)
<input type="checkbox"/> Copy given to patient	Ultrasound (B7)	Cardiopulmonary PT	Other: _____
<input type="checkbox"/> Copy attached to chart	Electrotherapy (B8)	Pain Management	
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	

<input type="checkbox"/> Modality used _____ <input type="checkbox"/> Location _____ <input type="checkbox"/> Frequency _____ <input type="checkbox"/> Duration _____ <input type="checkbox"/> Intensity _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Modality used _____ <input type="checkbox"/> Location _____ <input type="checkbox"/> Frequency _____ <input type="checkbox"/> Duration _____ <input type="checkbox"/> Intensity _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Modality used _____ <input type="checkbox"/> Location _____ <input type="checkbox"/> Frequency _____ <input type="checkbox"/> Duration _____ <input type="checkbox"/> Intensity _____ <input type="checkbox"/> Other _____
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ROM: \_\_\_\_\_  
 STRENGTH: \_\_\_\_\_  
 BALANCE: \_\_\_\_\_  
 AMBULATION: \_\_\_\_\_  
 ASSESSMENT: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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) \_\_\_\_\_

**SUPERVISORY VISIT (Complete if applicable)**

PT Assistant  Aide /  Present  Not present  
 SUPERVISORY VISIT  Scheduled  Unscheduled  
 OBSERVATION OF \_\_\_\_\_  
 TEACHING/TRAINING OF \_\_\_\_\_  
 PATIENT/FAMILY FEEDBACK ON SERVICES/CARE (specify) \_\_\_\_\_  
 NEXT SCHEDULED SUPERVISORY VISIT \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 CARE PLAN UPDATED?  No  Yes (specify) \_\_\_\_\_  
 If PT assistant/aide not present, specify date he/she was contacted regarding updated care plan: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SIGNATURES/DATES**

X _____ / / Patient/Caregiver (if applicable) Date	Complete TIME OUT prior to signing below. _____ / / Therapist (signature/title) Date
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**PART 1 - Clinical Record      PART 2 - Therapist**

PATIENT NAME - Last, First, Middle Initial	ID#
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\*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: \_\_\_\_\_

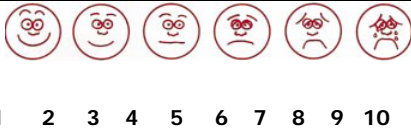
LIVING SITUATION

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



Location(s) \_\_\_\_\_
Pain (describe) \_\_\_\_\_
Impact on Function \_\_\_\_\_
Previous Pain Level \_\_\_\_\_

CURRENT ADL/IADLs

Table with 8 columns: AREA, STRENGTH (RIGHT, LEFT), ACTION, ROM (degrees) (RIGHT, LEFT), TASK, LEVEL OF ASSIST, ASSISTIVE DEVICES/ COMMENTS. Rows include Shoulder, Elbow, Forearm, Wrist, Fingers, Hip, Knee, Ankle, Foot, and various tasks like Bed Mobility, Roll/Turn, Sit/Supine, Scoot/Bridge, Transfers, Bed/Wheelchair, Toilet, Floor, Auto, Balance, Static Sitting, Static Standing, Dynamic Sitting, Dynamic Standing, Wheel, Chair, Skills, Propulsion, Pressure Reliefs, 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 Tinetti Forms can be attached if appropriate for evaluation**

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

**REHAB POTENTIAL/ DISCHARGE PLANS**

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

**Current Goals that pertain to current illness** | **Progress Toward Goals/ Lack of Progress Toward Goals**

Pt. will _____ assist with bed mobility within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits.	
Pt. to demonstrate increased strength of _____ (include specific joint, muscle, and indicate left, right or bilat.) to _____ within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt. &/or cg will demonstrate comprehension of home exercise program within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits.	
Pt will verbalize pain relief from ____/10 to ____/10 within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits.	
Pt. will demonstrate increased ____ ROM of _____ to _____ degrees within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Pt/cg will demonstrate _____ transfers with _____ level of assist within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits.	
Pt will ambulate _____ feet with _____ assistance <input type="checkbox"/> with <input type="checkbox"/> without _____ assistive device within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Increase _____ sitting balance to _____ within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
Increase _____ standing balance to _____ within _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<b>Additional Current Goals</b>	

**Other:**

**Other:**

**Other:**

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

New Goals:	Functional Reassessment Expectation of Progress Toward Goals
<b>If lack of progress to goals: therapist and physician determination of need for continuation</b>	
<b>Supportable statement to continue therapy and why goals attainable:</b>	
<b>Safety (PT to document noted safety concerns and the training needed to address them):</b>	
<b>Treatment Provided This Visit:</b>	
<b>Plan for next visit:</b>	
<b>Patient/Caregiver response to Plan of Care:</b>	
<b>Care coordination/ interdisciplinary communication ( to address findings and plans to continue) with:</b> <input type="checkbox"/> Physician <input type="checkbox"/> SN	
<input type="checkbox"/> Case Manager <input type="checkbox"/> PTA <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> Other (specify) _____	
<b>Changes to the POC:</b>	
<b>Patient/Client Signature</b> _____ <b>Therapist Signature/Title</b> _____	
Date ____/____/____ Time In _____ Time Out _____ Date ____/____/____ QI Review <input type="checkbox"/> Yes Frequency Verified <input type="checkbox"/>	
Yes	

<b>PATIENT/CLIENT NAME - Last, First, Middle Initial</b>	<b>ID#</b>
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# PHYSICAL THERAPY VISIT NOTE

VISIT DATE: \_\_\_ / \_\_\_ / \_\_\_

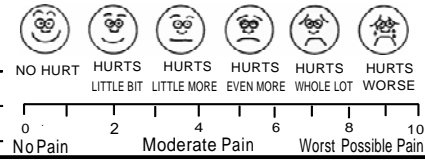
**VITAL SIGNS:** Pulse: \_\_\_\_\_  Regular  Irregular      Respiration: \_\_\_\_\_  Regular  Irregular  
Blood Pressure: Right \_\_\_\_\_ / \_\_\_\_\_ Left \_\_\_\_\_ / \_\_\_\_\_  Lying  Standing  Sitting

**PAIN:**  None  Same  Improved  Worse

Location(s) \_\_\_\_\_

Frequency:  Constant  Intermittent  Occasional Intensity 1 - 10 \_\_\_\_\_

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 <input type="checkbox"/> Copy given to patient <input type="checkbox"/> 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# \_\_\_\_\_

**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
- Cardiac
- Diabetes
- Respiratory
- Osteoporosis
- Fractures
- Cancer
- Arthritis
- Other (specify) \_\_\_\_\_
- Immunosuppressed

**REASON FOR EVALUATION (Diagnosis/Problem/History)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LIVING SITUATION**

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

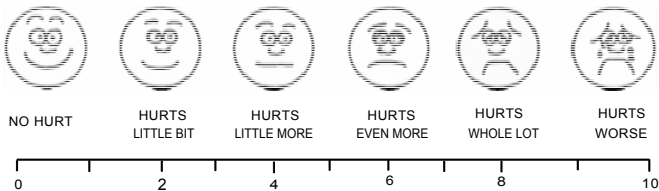
**HOME SAFETY BARRIERS:**

- 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:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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#

MUSCLE STRENGTH / FUNCTIONAL ROM EVAL					FUNCTIONAL INDEPENDENCE/BALANCE EVAL					
AREA	STRENGTH		AREA	ROM		TASKS	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS		
	Right	Left		Right	Left					
UPPER EXTREM.	Shoulder		Flex/Extend			Roll/Turn				
			Abd./Add.			Sit/Supine				
			Int. Rot./Ext. Rot.			Scoot/Bridge				
UPPER EXTREM.	Elbow		Flex/Extend			Sit/Stand				
		Forearm		Sup./Pron.			Bed/Wheelchair			
			Wrist		Flex/Extend			Toilet		
UPPER EXTREM.	Fingers		Flex/Extend			Floor				
		LOWER EXTREM.	Hip		Flex/Extend			Auto		
					Abd./Add.			Static Sitting		
	Int. Rot./Ext. Rot.					Dynamic Sitting				
LOWER EXTREM.	Knee		Flex/Extend			Static Standing				
		Ankle		Plant./Dors.			Dynamic Standing			
			Foot		Inver./Ever.			Propulsion		
SPINE	AREA	STRENGTH	ACTION	ROM	W/C SKILLS	Pressure Reliefs				
						Foot Rests				
						Locks				

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH				FUNCTIONAL INDEPENDENCE SCALE (bed mobility, transfers, balance, W/C Skills)			
GRADE	DESCRIPTION			GRADE	DESCRIPTION		
5	Normal functional strength - against gravity - full resistance			6	Independent - physically able and independent		
4	Good strength - against gravity with some resistance			5	Supervision and/or verbal cues - 100% patient effort		
3	Fair strength - against gravity - no resistance - safety compromise			4	Contact guard - 100% patient effort		
2	Poor strength - unable to move against gravity			3	Minimum assist (Min A) - 75% patient/client effort		
1	Trace strength - slight muscle contraction - no motion			2	Moderate assist (Mod A) - 50% patient effort		
0	Zero - no active muscle contraction			1	Maximum assist (Max A) - 25%-50% patient/client effort		
				0	Totally dependent - total care/support		

FUNCTIONAL RANGE OF MOTION (ROM) SCALE				SAFETY ISSUES			
GRADE	DESCRIPTION		GRADE	DESCRIPTION			
5	100% active functional motion		2	25% active function motion		<input type="checkbox"/> Obstructive pathways	<input type="checkbox"/> Equipment in poor condition
4	75% active functional motion		1	Less than 25%		<input type="checkbox"/> Home environment	<input type="checkbox"/> Bathroom
3	50% active functional motion					<input type="checkbox"/> Stairs	<input type="checkbox"/> Impaired judgement/safety
						<input type="checkbox"/> Unsteady gait	<input type="checkbox"/> Other (specify) _____
						<input type="checkbox"/> Verbal cues required	

**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): \_\_\_\_\_

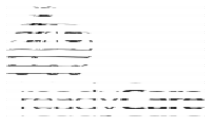
**QUALITY/DEVIATIONS/POSTURES:** \_\_\_\_\_

**SUMMARY**

**INSTRUCTION PROVIDED:**  Safety  Exercise  Other (describe) \_\_\_\_\_

Equipment needed (describe) \_\_\_\_\_

<p><b>DISCHARGE DISCUSSED WITH:</b> <input type="checkbox"/> Patient/Family <input type="checkbox"/> Care Manager <input type="checkbox"/> Physician  <input type="checkbox"/> Other (specify) _____</p> <p><b>CARE COORDINATION:</b> <input type="checkbox"/> None <input type="checkbox"/> Physician <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST  <input type="checkbox"/> MSW <input type="checkbox"/> PTA <input type="checkbox"/> COTA <input type="checkbox"/> Aide <input type="checkbox"/> Case Manager  <input type="checkbox"/> Other (specify) _____</p>	<p><b>APPROXIMATE NEXT VISIT DATE:</b> ___/___/___</p> <p><b>PLAN FOR NEXT VISIT</b> _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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# 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 <input type="checkbox"/> Copy given to patient <input type="checkbox"/> 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#

## 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

- 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

#### 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

#### 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



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/R 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

<p><b>POC (485) GOALS REACHED:</b></p> <p><input type="checkbox"/> PATIENT DEMONSTRATED CORRECT BODY MECHANICS</p> <p><input type="checkbox"/> PATIENT AND/OR CG COMPREHEND AND DEMONSTRATED HOME EXERCISE PROGRAM</p> <p><input type="checkbox"/> ABLE TO COMPLY WITH EXERCISES: BOTH PASSIVE AND ACTIVE EXERCISE REGIMEN</p> <p><input type="checkbox"/> DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM</p> <p><input type="checkbox"/> IMPROVED THE USE OF ASSISTIVE DEVICE: _____</p>	<p><input type="checkbox"/> MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM</p> <p><input type="checkbox"/> PATIENT AMBULATED WITH _____ (device) FOR _____ FT WITH _____ ASSIST</p> <p><input type="checkbox"/> INCREASED STRENGTH OF <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.</p> <p><input type="checkbox"/> INCREASED RANGE OF MOTION (ROM) OF _____ JOINT TO _____ DEGREE FLEXION AND _____ DEGREE EXTENSION IN _____ WEEKS TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITY: _____.</p>
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<p><b>CARE PLAN SHORT/LONG TERM GOALS REACHED:</b></p> <p><b>GENERAL</b></p> <p><input type="checkbox"/> Gait increased tinetti gait score to _____ / 12</p> <p><input type="checkbox"/> Improved gait requiring _____ to _____ from _____ to _____</p> <p><b>BED MOBILITY</b></p> <p><input type="checkbox"/> Pt. able to turn side (facing up) to lateral (left/right)</p> <p><input type="checkbox"/> Pt. able to lie back down</p> <p><input type="checkbox"/> Pt. able to sit up independently _____</p> <p><input type="checkbox"/> Pt. able to self reposition</p> <p><input type="checkbox"/> IMPROVED BED MOBILITY (INDEPENDENT)</p> <p><b>BALANCE</b></p> <p><input type="checkbox"/> Increased tinetti balance score to _____/16</p> <p><input type="checkbox"/> Pt. able to reach steady static/dynamic sitting/standing balance with/without assistance</p> <p><b>TRANSFER</b></p> <p><input type="checkbox"/> Pt. able to transfer from _____ to _____ with/without assistance</p> <p><input type="checkbox"/> INDEPENDENT WITH TRANSFER SKILLS</p> <p><b>STAIR/UNEVEN SURFACE</b></p> <p><input type="checkbox"/> Pt. able to climb stair/uneven surface with/without assistance _____ steps # _____</p>	<p><b>MUSCLE STRENGTH</b></p> <p><input type="checkbox"/> Pt. able to hold weigh _____ lb</p> <p><input type="checkbox"/> Pt. able to oppose flexion or extension force over _____</p> <p><b>PAIN</b></p> <p><input type="checkbox"/> Pain decreased from _____/10 to _____/10</p> <p><input type="checkbox"/> DEMONSTRATED EFFECTIVE PAIN MANAGEMENT</p> <p><input type="checkbox"/> PATIENT EXPERIENCED A DECREASE IN PAIN</p> <p><b>ROM</b></p> <p><input type="checkbox"/> Pt. increased ROM of _____ by _____ degrees flexion/extension</p> <p><b>SAFETY</b></p> <p><input type="checkbox"/> Pt. able to use _____ independently to _____ feet</p> <p><input type="checkbox"/> Pt. able to self propel wheel chair _____ feet</p> <p><input type="checkbox"/> Pt able to finalize and demonstrated to follow up HEP.</p> <p><b>OTHER:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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## ADDITIONAL SPECIFIC THERAPY GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

<p><b>DISCHARGE INSTRUCTIONS DISCUSSED WITH:</b> <input type="checkbox"/> Patient/Family</p> <p><input type="checkbox"/> Care Manager <input type="checkbox"/> Physician <input type="checkbox"/> Other (specify) _____</p> <p><b>CARE WAS COORDINATED:</b> <input type="checkbox"/> Physician <input type="checkbox"/> OT <input type="checkbox"/> SN <input type="checkbox"/> ST</p> <p><input type="checkbox"/> MSW <input type="checkbox"/> Aide <input type="checkbox"/> PTA <input type="checkbox"/> Other (specify) _____</p>	<p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> RETURNED TO INDEPENDENT LEVEL OF SELF CARE.</p> <p><input type="checkbox"/> ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____</p>
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<p><b>REHAB STATUS:</b> <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent</p> <p><input type="checkbox"/> DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED</p> <p><input type="checkbox"/> ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE</p>	<p><input type="checkbox"/> 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.</p>
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Goals documented by: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Name/Signature/title

PATIENT NAME - Last, First, Middle Initial	ID#
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