



# PHYSICAL THERAPY EVALUATION (CONT'D)

MUSCLE STRENGTH/FUNCTIONAL ROM EVALUATION					FUNCTIONAL INDEPENDENCE/BALANCE EVAL					
	AREA	STRENGTH		ACTION	ROM		TASK	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS	
		Right	Left		Right	Left				
UPPER EXTREMITY	Shoulders			Flex/Extend			Roll/Turn			
				Abd./Add.			Sit/Supine			
				Int. rot./Ext. rot.			Scoot/Bridge			
	Elbow			Flexion			Sit/Stand			
				Extension			Bed/Wheelchair			
	Forearm			Sup./Pron.			Toilet			
	Wrist			Flex/Extend			Shower			
	Fingers			Flex/Extend			Auto			
	LOWER EXTREMITY	Hip			Flex/Extend			Static Sitting		
					Int. rot./Ext. rot.			Dynamic Sitting		
Knee				Abd./Add.			Static Standing			
				Flexion			Dynamic Standing			
Ankle			Extension			Propulsion				
Foot			Plant./Dors.			Pressure Reliefs				
SPINE			Inver./Ever.			Foot Rests				
	AREA	STRENGTH		ACTION	ROM		Locks			
							Wheelchair Mobility			

**TUG:** \_\_\_\_\_ Seconds  
**TINETTI:** \_\_\_\_\_ /28 (Assistive device used);  
**DGI:** \_\_\_\_\_ /12 (Assistive device used);  
**Other:** \_\_\_\_\_

## OBJECTIVE DATA TESTS AND SCALES

### MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

### STANDARDIZED BALANCE/FALL RISK TESTS

GRADE	DESCRIPTION	DESCRIPTION
5	Normal functional strength – against gravity – full resistance.	<b>TUG (Timed Up and Go):</b> Greater than 14 seconds the patient is risk for fall. <b>TINETTI (Balance and Gait):</b> Under 19 = High risk of falls 20 – 24 = Moderate risk; 24 and up = Low risk. <b>DGI (Dynamic Gait Index):</b> > 9 = Increased fall risk.
4	Good strength – against gravity – no resistance.	
3	Fair strength – against gravity – no resistance – safety compromise.	
2	Poor strength – unable to move against gravity.	
1	Trace strength – slight muscle contraction – no motion.	
0	Zero – no active muscle contraction.	

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

### FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION	GRADE	DESCRIPTION
5	Independent (I) – physically able and independent.	5	100% of active functional motion.
4	Verbal cues (VC) only needed.	4	75% of active functional motion.
3	Stand-by assist (SBA) – 100% patient/client effort.	3	50% of active functional motion.
2	Minimum assistant (Min A) – 75% of patient/client effort.	2	25% of active functional motion.
1	Maximum assistant (Max A) – 25% – 50% patient/client effort.	1	Less than 25%.
0	Totally dependent – total care/support.		

### GAIT

**ASSISTANCE:**  Independent  SBA  Min. assist  Mod. assist  Max. 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  Front Wheel Walker  Other (specify): \_\_\_\_\_  
**QUALITY/DEVIATION/POSTURE:** \_\_\_\_\_

### SUMMARY

**Instruction Provided:**  Safety  Exercise  Other (describe): \_\_\_\_\_  
**EQUIPMENT (available):** \_\_\_\_\_ (condition): \_\_\_\_\_ (needs): \_\_\_\_\_  
 PT Evaluation only (reasons for no further visit planned):  Patient refused  Not home bound  Optimal level of function  Cognitive deficits  
 Other (specify): \_\_\_\_\_  
**DISCHARGE DISCUSSED WITH:**  Patient/Caregiver  Family  Physician  Other (specify): \_\_\_\_\_  
**CARE COORDINATION:**  Physician  SN  PTA  OT  ST  MSW  Aide  Other (specify): \_\_\_\_\_

<b>PRINT PATIENT NAME: (LAST, FIRST)</b>	<b>PATIENT/CAREGIVER Signature:</b>
<b>PRINT THERAPIST NAME:</b>	<b>THERAPIST SIGNATURE:</b>

**MR #:** \_\_\_\_\_ **TIME IN:** \_\_\_\_\_ **TIME OUT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# H & M Health Services, Inc.

## PHYSICAL THERAPY SERVICE ORDER/CARE PLAN

Telephone Order (Physician signature required)

Date of Telephone Order: \_\_\_\_\_

<b>PATIENT NAME:</b>	Patient I.D. #:
Physician Name:	Assessment Date:
Therapist Assigned:	Planned D/C Date:
Frequency/Duration:	Onset/Exacerbation Date:

Treatment Diagnosis(es)/Problems: \_\_\_\_\_

Type of Evaluation (please check one):  New Admission  Resumption of Care  Recertification of Care

THERAPEUTIC INTERVENTION TO BE CONTINUED (Mark all applicable with an 'X')			
Evaluation/Reevaluation (B1)	Transfer training (B3)	Preprosthetic training	Pain Management
Establish/Upgrade home exercise program (B4)	Muscle strengthening	Prosthetic training (B9)	TENS
<input type="checkbox"/> Copy given to patient	Teach bed mobility skills	Teach safe/effective use of adaptive/assistive device (specify):	Ultrasound (B7) @ _____ w/cm2
<input type="checkbox"/> Copy placed in folder	Functional mobility training		8 - 10 mins 1x (area): _____
Patient/Family education	Balance training/activities	Management and evaluation of care plan (B 12)	Electrotherapy (B8)
Therapeutic exercises (B2)	Teach safety precautions	Teach fall prevention	Manual Therapy (specify):
Gait training (B 5)	Home Safety	Other:	Teach application of Heat/Cold
Teach safety stairs/climbing skills	Neuro-muscular re-education (B11)		

REHAB POTENTIAL/DISCHARGE PLANS (Mark all applicable with an 'X')		
<b>Rehab Potential:</b> Good with Patient able to return to previous level of activity and improvement in functional status in accordance with Patient's endurance level.	<b>Rehab Potential:</b> Good for stated goals.	<b>Discharge Plan:</b> Patient will be discharged when Patient is able to function independently within current limitations at home.
<b>Rehab Potential:</b> Good for Patient to be able to follow the plan or care/treatment regimen, and be able to self manage his/her condition.	<b>Rehab Potential Guarded:</b> Minimal improvement in functional status expected and decline is possible.	<b>Discharge Plan:</b> Patient will be discharged when Patient is able to function with assistance of caregiver within current limitations at home.
<b>Rehab Potential Fair:</b> Patient will develop functional mobility within the home care setting.	<b>Other:</b>	<b>Discharge Plan:</b> Patient will be discharged from Physical Therapy when Patient has met Optimal Rehab potential and/or stated goals are met.

PHYSICAL THERAPY GOALS	
<input type="checkbox"/> Patient will increase muscle strength in _____ to _____ /5 in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Patient will increase AROM in _____ to _____ ° in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Patient will increase gait to _____ feet with _____ assist with _____ (assistive device) in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Patient will be able to climb stairs/walk on uneven surfaces with _____ assist in order to safely leave home with _____ assist in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits.	
<input type="checkbox"/> Patient will improve bed mobility with _____ assist in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Patient will improve (specify surface) _____ transfer with _____ assist using (AD) _____ in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Patient will demonstrate improved <input type="checkbox"/> sitting <input type="checkbox"/> standing balance <input type="checkbox"/> static <input type="checkbox"/> dynamic to _____ /5 in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits in order to decrease risk for falls.	
<input type="checkbox"/> Patient/caregiver will demonstrate proper use and care of prosthetic/orthotic devices in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Patient will verbalize/and or demonstrate increased safety awareness in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits to decrease risk of falls.	
<input type="checkbox"/> Patient/caregiver will verbalize/and or demonstrate fall prevention techniques _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Patient will verbalize pain relief from _____ /10 to _____ /10 in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Patient/Caregiver will demonstrate the ability to follow H.E.P in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Patient will show a decrease in fall risk by an improvement in: <input type="checkbox"/> TUG score to _____ seconds <input type="checkbox"/> Tinetti Balance/Gait score to _____ /28	
<input type="checkbox"/> DGI score to _____ /12 <input type="checkbox"/> MCTSIB _____ /4 in _____ <input type="checkbox"/> weeks <input type="checkbox"/> visits	
<input type="checkbox"/> Other:	

**60 Day Summary (Recertification only):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dr. \_\_\_\_\_ may also write orders for the care of this patient.

I have read the above evaluation and approve of the Plan of Care:

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_