H&M HEALTH SERVICES, INC

PHYSICAL THERAPY VISIT NOTE

VISIT: ☐ Scheduled ☐ Supervisor

Heart Rate: ☐ Rest _______ min Exercise: _______ min Recovery Rate: _______ min Coping Ability: _______ B/P: R_______
Respiration: ☐ Rest _______ min Exercise: _______ min Recovery Rate: _______ min Good/Fai8r/Poor L_______

PAIN ASSESMENT: ☐ Denies pain ☐ Intensity (1-10) _______ Site: _______________
Description: ☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Intractable
Relieved by: _______________ Effective: ☐ YES ☐ NO

No Pain — Mod Pain — Worst Pain
0 1 2 3 4 5 6 7 8 9 10

SKILLED INTERVENTIONS (Mark all Interventions Provided)

☐ EVALUATION
☐ THERAPEUTIC EXERCISES
☐ Passive ☐ Active ☐ Assistive ☐ Resistive ☐ Other
☐ TRANSFER TRAIN
☐ Bed/Chair/Toilet ☐ Shower/Tub ☐ Bed mobility ☐ Auto ☐ Floor
☐ EXERCISE PROGRAM
☐ Establish HEP ☐ Upgrade HEP (explain)_______________
☐ GAIT TRAINING MOBILITY:
☐ WB status _______________
☐ Ambulation Device_______________
☐ Other:_______________
☐ PULMONARY THERAPY:
☐ Breathing Exercises ☐ Postural Drainage ☐ Chest percussion
☐ Other:_______________

☐ ULTRASOUND
☐ __________ w/cm x __________ min to __________
☐ ELECTROTHERAPY: ☐ Tens area:_______________
☐ PROSTHETIC TRAINING
☐ Stump Care ☐ Prosthetic Fit
☐ MUSCLE RE-EDUCATION:
☐ Muscle re-education for:_______________
☐ OTHER:
☐ Safety Training ☐ Equipment Training
☐ Pain Management (specify:_______________
☐ Whirlpool ☐ Energy Conservation
☐ Other Modalities: _______________
☐ Other modalities:_______________
☐ Other Modalities:_______________

PATIENT REMAINS HOMEBOUND (State Reason)_______________

CLINICAL SUMMARY (Assessment, Skilled Interventions and Education)

____
____
____
____
____
____

PATIENT/CAREGIVER RESPONSE TO EDUCATION: WRITE RESPONSE IN CODE SPACE BEFORE THE AREA EDUCATED: PATIENT/CAREGIVER RESPONSE CODES: 1-Partial understanding 2-Verbalizes Understanding 3-Returns Demonstration 4-Needs further Education 5-Goals met

# THERAPEUTIC EXERCISES	#PULMONARY THERAPY	#MUSCLE RE-EDUCATION	#HOME EXERCISE PROGRAM
______ Teach Exercises	______ Teach Breathing Exercises	______ Teach Muscle Re-Education for:_________	______ Teach HEP
______ Balance Instruction	______ Teach postural Drainage	______ Teach:_________	#OTHER
______ Coordination Instruction	______ Teach Chest Percussion	#PROSTHETIC/ORTHOTIC TRAINING	______ Teach Safety
# TRANSFER TRAINING	______	______ Teach Stump Care	______ Teach Equipment use
______ Teach Supine/Sit	Teach:_________	______ Teach Prosthetic Fit	______ Teach Energy Conservation
______ Teach Sit/Stand	#GAIT TRAINING/MOBILITY	#ELECTRO THERAPY	______ Teach Pain Management
______ Teach Toilet/Bed/Chair	______ Teach WB Status	______ Teach TENS use	______ Teach Joint Precaution
______ Teach Bed mobility	______ Teach Ambulation		______ Teach Body mechanics
______ Teach:_________	______ W/C Mobility		

SUPERVISION ☐ Aide ☐ PTA Present: ☐ YES ☐ NO
Care Plan Followed: ☐ YES ☐ NO
Care Plan revised: ☐ YES ☐ NO
Progress Towards Goals: ☐ YES ☐ NO
Patient/Caregiver satisfied with care: ☐ YES ☐ NO

MEDICATIONS/REVISIONS
☐ Medication Regime Assessed ☐ RN Managing Medication Regime
☐ New/Changed Orders_______________
☐ Pt/S/O aware
☐ Med Profile/Care Plan Updated

COORDINATION OF SERVICES
☐ Communication/Case Conference with
Phys/PCC/Sch/Other:_______________Regarding_______________
☐ Universal Precautions ☐ New Orders Received_______________ ☐ Mod Written
Physician Next Visit:_______________ Next Therapy Visit:_______________ DISCHARGE PLANNING ☐ In Progress ☐ Complete

PATIENT/REPRESENTATIVE, PLEASE SIGN AND DATE TO CONFIRM THE TIME AND DATE OF THE PHYSICAL THERAPY VISIT STATED BELOW

Signature of patient or Acting Representative Relationship

X

Therapist's Signature Date: Time In: Time Out:

Patient Name (Print) Identified by:

Last First