

PHYSICAL THERAPY EVALUATION

DATE OF SERVICE ___/___/___
TIME IN ___ TIME OUT ___

- Initial Evaluation
- Re-Evaluation (Type) _____

- Q5001: Hospice or Home Health Care provided in patient's home/residence
- Q5002: Hospice or Home Health Care provided in Assisted Living Facility
- Q5009: Hospice or Home Health Care provided in place not otherwise specified

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) _____

SOC DATE ___/___/___
 G0151 G0159 Maintenance

PERTINENT BACKGROUND INFORMATION

Prior Level of Functioning:
 ADLs: Independent Needed assist
 Total assist
 In Home Mobility: Independent Assistive device
 Wheelchair/scooter Non-ambulatory
 Community Mobility: Independent
 Assistive device Wheelchair/scooter
 Non-ambulatory

PERTINENT MEDICAL INFORMATION

Onset Date: ___/___/___
 Primary Diagnosis: _____
 Medical Precautions/Limitations:
 Hypertension Cardiac Diabetes Respiratory Osteoporosis
 Fractures Cancer Infection Immunosuppressed Open Wound
 Other: _____

History of Falls:
 Y/N If yes, date of last fall: ___/___/___
 Intervention in place? Yes No
 If yes, specify: _____

PAIN

Rating scale: 0 1 2 3 4 5 6 7 8 9 10
No pain Mod pain Worst pain Current pain level: _____
(subjective reporting)
 Best pain gets: _____ Worst pain gets: _____ Acceptable level: _____
 Pain quality: _____ Pain location: _____
(ache, sharp, dull, etc.)
 Frequency: Occasionally Continuous Intermittent
 What makes pain worse? Movement Ambulation Immobility
 Other: _____
 Referral needed? Yes No Referred to: _____
 Impacting function? Yes No (specify) _____

Reported by: Patient Family Caregiver
Living Arrangements/Support System:
 Lives alone Caregiver available
 Limited support No caregiver available
 Comment: _____

POC Goal Needed? Yes No

Environmental Barriers: Clutter Throw rugs
 Adaptive equipment needed: Yes No
 (specify) _____

Other: _____

VITAL SIGNS

Blood Pressure: Sitting/lying R _____ L _____
 Standing R _____ L _____
Temperature: _____ Oral Axillary Other: _____
Pulse: Apical _____ Brachial _____ Radial _____
 Rhythm: Regular Irregular
Respirations: _____ Regular Irregular
 O₂ @ _____ LPM via: Cannula Mask Trach
 O₂ saturation ____%: At rest With activity
 Impacting function? Yes No (specify) _____

BEHAVIOR/MENTAL STATUS

Alert Oriented Cooperative Confused
 Memory deficits: Short term Long term Impaired judgment
 Other: _____
 Impacting function? Yes No (specify) _____

POC Goal Needed? Yes No

POC Goal Needed? Yes No

GAIT

Assistance: Independent SBA CGA Min. assist Mod. assist Max. assist Dependent
Adaptive Device: No device Crutches FWW 4WW Hemi Walker SBOC LBQC SPC Other: _____
Surfaces within Functional Area: Level Uneven Stairs (# if known _____) Distance/Time: _____/_____
Functional Distance Needed for: Toileting: _____ ft Bed: _____ ft Chair: _____ ft
Weight Bearing Status: FWB WBAT PWB TDWB NWB
Gait Quality/Deviations/Postures: _____
 Impacting function? Yes No (specify) _____

POC Goal Needed? Yes No

Comments: _____

PATIENT NAME - Last, First, Middle Initial

ID#

PHYSICAL THERAPY EVALUATION (Cont'd.)

MUSCLE STRENGTH/FUNCTIONAL ROM EVAL						FUNCTIONAL INDEPENDENCE/BALANCE EVAL			
AREA	STRENGTH		ACTION	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			
	Elbow			Flex/Extend		Sit/Stand			
		Forearm			Sup./Pron.		Bed/Wheelchair		
			Wrist			Flex/Extend			Toilet
LOWER EXTREM.	Hip			Flex/Extend		Floor			
				Abd./Add.		Auto			
				Int. Rot./Ext. Rot.		Static Sitting			
	Knee			Flex/Extend		Dynamic Sitting			
	Ankle			Plant./Dors.		Static Standing			
	Foot			Inver./Ever.		Dynamic Standing			
SPINE	AREA	STRENGTH	ACTION	ROM					

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH	
GRADE	DESCRIPTION
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.
0	Zero - no active muscle contraction.

FUNCTIONAL INDEPENDENCE SCALE (For Balance/Mobility, Self Care/ADL Skills, IADL Skills)	
GRADE	DESCRIPTION
7	Independent.
6	Modified independent - verbal cues, extra time.
5	Stand-by assist (SBA) - 100% effort w/supervision.
4	Minimal assist - 75% effort.
3	Moderate assist - 25-50% effort.
2	Maximum assist - 25% effort.
1	Dependent/unable to do task <25% effort.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE			
GRADE	DESCRIPTION	GRADE	DESCRIPTION
5	100% active functional motion.	2	25% active functional motion.
4	75% active functional motion.	1	Less than 25%.
3	50% active functional motion.		

Comments: _____

SUMMARY

Education/Instruction provided: Safety Exercise Other (Describe) _____

PT evaluation only. No further indications for PT services

Was a standardized/validated assessment used? Yes No If yes (specify assessment): _____

Results: _____

Orders for PT evaluation only. Needs additional PT services. See PT Care Plan/485 for recommendations.

Need to obtain orders: (specify) _____

Orders for PT services with specific treatments, frequency and duration. See PT Care Plan/485.

Other disciplines providing care: SN OT ST MSW Aide Other: _____

Equipment recommendations: (specify) _____

There are no changes to the POC based upon this assessment, at this time.

Was a need identified or reported during this assessment in any of the following areas that requires a referral? Nutrition Medications

Pain Injuries/Wounds Psychosocial concerns Self care skills IADLs Safety issues Other: _____

Yes No If Yes: (specify) _____

Referral recommendations: (specify) _____

Comments: _____

DISCHARGE DISCUSSED WITH: Patient Family/Caregiver Care Manager

Physician Other: _____

BILLABLE SUPPLIES: N/A Yes (specify) _____

CARE COORDINATION: Physician Nursing PT OT ST MSW

Aide Other _____

APPROXIMATE NEXT VISIT DATE: ____/____/____

PLAN FOR VISIT: _____

SIGNATURES/DATES

X _____ Date ____/____/____

Complete TIME OUT (on previous page) prior to signing below.

Therapist (signature/title) Date ____/____/____

PHYSICAL THERAPY CARE PLAN

SOC DATE: ___/___/___

Primary Diagnosis: _____ Onset Date: ___/___/___

Treatment Diagnosis/Problem Areas: _____

HOMEBOUND REASON:

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

Frequency and Duration: _____

PHYSICAL THERAPY INTERVENTIONS

- Establish HEP: Given to Pt In Chart
- Patient/Family/Caregiver Education
- Adaptive Equipment Training
- Therapeutic Exercise
- Neuro-Muscular Re-education
- Gait Training
- Modalities: TENS Ultrasound
- E-stim Heat Ice
- Balance
- Pulmonary PT
- Orthotic Fitting/Fabrication/Training
- Prosthetic Fitting/Fabrication/Training
- Functional Mobility
- Other: _____

GOALS/OUTCOMES: Patient/Therapist identified functional based goals (areas identified in evaluation)

Functional Goal Area Identified at Eval:	Functional Short Term Goal #1: Measurable and date by: ___/___/___	Functional Long Term Goal #1: Measurable and date by: ___/___/___
Functional Goal Area Identified at Eval:	Functional Short Term Goal #2: Measurable and date by: ___/___/___	Functional Long Term Goal #2: Measurable and date by: ___/___/___
Functional Goal Area Identified at Eval:	Functional Short Term Goal #3: Measurable and date by: ___/___/___	Functional Long Term Goal #3: Measurable and date by: ___/___/___
Functional Goal Area Identified at Eval:	Functional Short Term Goal #4: Measurable and date by: ___/___/___	Functional Long Term Goal #4: Measurable and date by: ___/___/___
Functional Goal Area Identified at Eval:	Functional Short Term Goal #5: Measurable and date by: ___/___/___	Functional Long Term Goal #5: Measurable and date by: ___/___/___

Adaptive equipment needs identified? Yes No If Yes (specify): _____

Patient/Family/Caregiver aware and in agreement of POC? Yes No If No (specify): _____

Discharge Plan: When goals are met Other (specify): _____

Comments: _____

Demonstrates Rehab Potential: Poor Fair Good Excellent

Patient demonstrates potential for continued gains towards a greater level of functional independence and will benefit from continued Physical Therapy Services to address deficit areas impacting his/her function. Please see Physical Therapy Evaluation and Plan of Care for further detailed information regarding current functional level and areas of focus.

Plan developed by: _____ Date: _____
Professional signature/title

Physical Therapy Care Plan and Physician Orders

NOTE: To be used ONLY for Supplemental Orders to Plan of Care/485 for Therapy Services.
When patient under hospice POC, the IDT determines changes to the POC with the medical director and/or attending physician.
Recommended Plan, Outcomes, Frequency & Duration as above.

Verbal orders from physician by: _____ Date: _____
Professional 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#