

Patient Name

Record #

THERAPY VISIT NOTE

Physical Occupational Speech

VITAL SIGNS

T _____
P _____
R _____
B/P _____
Wt _____
 Standard Precautions Maintained
Comments _____

BEHAVIOR / MENTAL STATUS

Alert/Oriented
 Anxious
 Willing to Learn/Improve
 Lethargic
 Apathetic
 Noncompliant
 Comatose
 Other _____
Comments _____

ASSESSMENT

SKIN

No Deficit Warm/Dry Cool/Clammy Targor Adequate
Wound #1 Location _____
L W D
DRAINAGE Amt _____
Color _____ Odor _____
WOUND BED
Color _____
Tissue _____
Pain _____
 Alterations in skin that impact plan: define _____
Comments _____

PAIN

See Additional Pain Assessment/Documentation (per agency policy)
Refer to: _____
Frequency of Pain Interfering with patient's activity or movement:
 0 - Patient has no pain 2 - Less often than daily
 1 - Patient has pain that does not interfere with activity or movement 3 - Daily, but not constantly 4 - All of the time
PAIN PROFILE Primary Site _____
Intensity: 0 1 2 3 4 5 6 7 8 9 10
LOW HIGH
Current pain management & effectiveness: _____
 Pain Management Teaching to patient/family (document below)
Patient's pain goal: _____
Progress toward pain goal: _____
Comments _____

Fall Precautions Maintained
Medication change since last visit? No Yes, Specify _____
Homebound? No Yes (if yes, reason) _____

TREATMENT

INTERVENTIONS

TEACHING

PATIENT RESPONSE TO TEACHING

Title of Teaching Tool used: _____ given to: Patient Caregiver Both
 Instruction PVCg, Verbalized Understanding PVCg, Return Demonstration

Home Therapy Program established? No Yes
Participation and follow through between visits is: Adequate Inadequate Not Applicable Other _____

Medical Equipment/Adaptive Devices/Supplies used this visit: _____

THERAPY/AIDE SUPERVISION (optional) PTA COTA AIDE Other _____

Present on this visit? Yes No Maintains open communications with patient representative (if any), caregivers and family? Yes No Reports changes in the patient's condition? Yes No
Follows the patient's plan of care? Yes No Complies with infection prevention and control policies and procedures? Yes No Additional instruction given during visit? Yes No
Honors patient's rights? Yes No Demonstrates competency with assigned tasks? Yes No Signature: _____ Date: _____

MEASURABLE PROGRESS TO GOALS/OUTCOMES

MEASURABLE SHORT TERM

MEASURABLE LONG TERM

COORDINATION/PLAN

Progress Towards Patient Goals: _____
Progress To Patient Outcomes: _____
Conferenced With: SN PT OT SLP MSS HHA (circle one) Name: _____
Regarding: _____

Physician Contacted Re: _____ Date/Time _____
Order Changes: _____
 Patient, Caregiver and/or Representative (if any) agreed with and participated in the changes to the POC

Plan For Next Visit: _____
Discharge Planning: _____

Update to Interdisciplinary Care Plan
Problem: _____
Intervention: _____
Goal: _____

Therapist Signature & Title _____ Time In _____ Time Out _____ Date _____
Check one: G0151-PT G0167-PTA G0162-OT G0158-OTA G0153-ST
Patient Signature _____ Date _____

Signature Validates Visit Date and Time