one staffing

PHYSICAL THERAPY EVALUATION

☐ 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

DATE OF SERVICE____/____/____
TIME IN_____ TIME OUT_____

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 MEDICAL INFORMATION

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

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
History of Falls:
Y/N If yes, date of last fall:____/____/____
Intervention in place? ☐ Yes ☐ No
If yes, specify:_____
Reported by: ☐ Patient ☐ Family ☐ Caregiver
Living Arrangements/Support System:
☐ Lives alone ☐ Caregiver available
☐ Limited support ☐ No caregiver available
Comment:_____
Environmental Barriers: ☐ Clutter ☐ Throw rugs
☐ Adaptive equipment needed: ☐ Yes ☐ No
(specify)_____
Other:_____

PAIN

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

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
O_2 @ _____LPM via: ☐ Cannula ☐ Mask ☐ Trach
O_2 saturation _____%: ☐ At rest ☐ With activity
Impacting function? ☐ Yes ☐ No (specify)_____
POC Goal Needed? ☐ Yes ☐ No

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

GAIT

Assistance: ☐ Independent ☐ SBA ☐ CGA ☐ Min. assist ☐ Mod. assist ☐ Max. assist ☐ Dependent
Adaptive Device: ☐ No device ☐ Crutches ☐ FWW ☐ 4WW ☐ Hemi Walker ☐ SBQC ☐ 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#

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PHYSICAL THERAPY EVALUATION (Cont'd.)

MUSCLE STRENGTH/FUNCTIONAL ROM EVAL

	AREA	STRENGTH Right	STRENGTH Left	ACTION	ROM Right	ROM Left
UPPER EXTREM.	Shoulder			Flex/Extend		
				Abd./Add.		
				Int. Rot./Ext. Rot.		
	Elbow			Flex/Extend		
	Forearm			Sup./Pron.		
	Wrist			Flex/Extend		
	Fingers			Flex/Extend		
LOWER EXTREM.	Hip			Flex/Extend		
				Abd./Add.		
				Int. Rot./Ext. Rot.		
	Knee			Flex/Extend		
	Ankle			Plant./Dors.		
	Foot			Inver./Ever.		

SPINE	AREA	STRENGTH	ACTION	ROM

FUNCTIONAL INDEPENDENCE/BALANCE EVAL

	TASKS	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS
BED MOBILITY	Roll/Turn		
	Sit/Supine		
	Scoot/Bridge		
TRANSFERS	Sit/Stand		
	Bed/Wheelchair		
	Toilet		
	Floor		
	Auto		
BALANCE	Static Sitting		
	Dynamic Sitting		
	Static Standing		
	Dynamic Standing		
W/C SKILLS	Propulsion		
	Pressure Reliefs		
	Foot Rests		
	Locks		

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 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.		

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.

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 _____ ____/____/____

Patient/Caregiver (if applicable) *Date*

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

_____ ____/____/____

Therapist (signature/title) *Date*

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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#