one Stating

Patient Name | Record #

# THERAPY VISIT NOTE

☐ Physical ☐ Occupational ☐ Speech

## ASSESSMENT

**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

**SKIN**
☐ No Deficit ☐ Warm/Dry ☐ Cool/Clammy ☐ Turgor Adequate

Wound #1
Location
L W D
DRAINAGE Amt
Color Odor
WOUND BED
Color
Tissue
Pain

Wound #2
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
☐ 1 - Patient has pain that does not interfere with activity or movement
☐ 2 - Less often than daily
☐ 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)

## INTERVENTIONS

**TREATMENT**

**TEACHING**

**PATIENT RESPONSE TO TEACHING**

Title of Teaching Tool used:
☐ Instruction ☐ Pt/Cg. Verbalized Understanding ☐ Pt/Cg. Return Demonstration given to: ☐ Patient ☐ Caregiver ☐ Both
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
Follows the patient's plan of care? ☐ Yes ☐ No
Honors patient's rights? ☐ Yes ☐ No
Maintains open communications with patient representative (if any), caregivers and family? ☐ Yes ☐ No
Complies with infection prevention and control policies and procedures? ☐ Yes ☐ No
Demonstrates competency with assigned tasks? ☐ Yes ☐ No
Reports changes in the patient's condition? ☐ Yes ☐ No
Additional instruction given during visit? ☐ 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:
Order Changes: Date/Time
☐ 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 ☐ G0157-PTA ☐ G0152-OT ☐ G0158-OTA ☐ G0153-ST

Patient Signature | Date

Signature Validates Visit Date and Time

WHITE – Medical Record YELLOW – Office/Home Chart

MED-PASS