

PHYSICAL THERAPY REVISIT NOTE

DATE OF SERVICE ____/____/____
 TIME IN ____ TIME OUT ____

- 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

VITAL SIGNS: Temp: _____ Pulse: _____ Regular / Irregular Resp.: _____ B/P: _____
 Using O₂ at _____ LPM via: _____
PAIN: Rating scale: 0 1 2 3 4 5 6 7 8 9 10 Current pain level: _____
No pain Mod pain Worst pain (subjective reporting)
 Pain quality: _____ Pain location: _____ Frequency: _____
(ache, sharp, etc.)
 Complete Briggs Pain Assessment #3459/2P per agency policy

TYPE OF VISIT:
 Revisit and Supervisory Visit
SOC DATE ____/____/____
 G0151 PT G0157 PTA

Safety Issues:
 Obstructed pathways Home environment
 Stairs Unsteady gait
 Verbal cues required
 Equipment in poor condition Bathroom
 Commode
 Others (specify): _____
 Referral Made: Yes No If Yes (specify) _____

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) _____

Treatment Diagnosis/Problem Area(s): Impaired gait quality, posture, deviation
 Coordination deficits (Fine/Gross) Decreased independence with functional transfers
 Lower body weakness/limited ROM Impaired balance, loss of balance
 Increased falls Limited functional mobility (w/c, ambulation, etc.)
 Impaired functional ambulation Other: _____

PHYSICAL THERAPY INTERVENTIONS

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

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

Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards Independence:
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Adaptive Equipment Needs Identified and/or Trained on: _____ Patient/Caregiver/Family Response: _____

Demonstrates Rehab Potential as: 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.

CARE PLAN: Reviewed/Revised with Patient/Caregiver/Family
 Revised Yes No (specify): _____
 APPROXIMATE NEXT VISIT DATE: ____/____/____
 PLAN FOR NEXT VISIT: _____
 DISCHARGE PLAN DISCUSSED WITH: Patient/Family
 Care Manager Physician Other: _____
 BILLABLE SUPPLIES USED? N/A Yes (specify): _____
 CARE COORDINATION DISCUSSED WITH: Physician Nursing
 PT OT ST MSW Aide Other: _____

SUPERVISORY VISIT (Complete if applicable)
 PT Assistant Aide / Present Not present
 Supervisory Visit: Scheduled Unscheduled
 Observation of: _____
 Teaching/Training of: _____
 Signature/Title: _____
 Next Scheduled Supervisory Visit: _____
 Care plan reviewed/revised with assistant/aide during this visit:
 Yes No If yes (specify): _____
 If PT assistant/aide not present, specify date he/she was contacted
 regarding updated care plan: ____/____/____

Comments: _____

SIGNATURES/DATES

X _____ Date ____/____/____ Complete **TIME OUT** (above) prior to signing below.
 Patient/Caregiver (if applicable) Therapist (signature/title) Date ____/____/____

PATIENT NAME - Last, First, Middle Initial _____ ID# _____