

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 _____

SKIN

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

ASSESSMENT

PAIN

See Additional Pain Assessment/Documentation (per agency policy)
Rater 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

This of Teaching Tool used:

Instruction P/Cg. Verbalized Understanding P/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 GOTA 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: _____

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