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 (No pain / Mod pain / Worst pain) Current pain level:_____ (subjective reporting)
Best pain gets:_____ Worst pain gets:_____ Acceptable level:_____
Pain quality:_____ (ache, 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#

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*

Physical Therapy Plan of Care

PHYSICIAN PLAN OF CARE - CHANGE AND ADDITIONAL ORDERS

Patient/Client Name: _____ Date: _____

Patient/Client Address: _____

Physician's Name: _____

Physician's Phone: _____ Fax: _____

County: _____

Dear Doctor:
The orders shown below are being forwarded for your signature to authorize your verbal orders given on this date. Please sign and return this form within three (3) days for our patient's chart. *Thank you for the referral of your patient for services.*

☐ Initial Evaluation ☐ Routine Visit
☐ Frequency/Duration _____ AS OF Date ____/____/____

☐ PT Evaluation
Date: ____/____/____

☐ Therapeutic Exercises
May include: ☐ active, ☐ active-assisted, ☐ passive, ☐ muscle stretching, ☐ resisted, ☐ PRE, ☐ PNF, ☐ Williams Flexion, ☐ Codmans Shoulder

☐ Transfer Training

☐ Home Exercise Program

☐ Gait Training
with (device)_____ at_____(weight-bearing status) and_____ (distance). Progress to _____at_____ and_____when medically indicated

☐ Cardiopulmonary Treatment
May include ☐ breathing exercises, ☐ postural drainage, ☐ cardiopulmonary conditioning, ☐ chest physiotherapy

☐ Ultrasound
at_____output for _____(time) to_____ _____(affected area)

☐ Electro Treatment
☐ EMS, ☐ MEDCO, ☐ FES
☐ HVGS, ☐ TENS for_____ (time) to_____(affected area)

☐ Prosthetic Training
May include ☐ Stump conditioning
☐ muscle str, ☐ ROM
☐ Gait training with/without prosthesis

☐ Muscle Re-education

☐ Management & Evaluation of Patient Care Plan

☐ Other
☐ Balance/coordination exercises
☐ ADL training
☐ Safety precaution instruction
☐ Body mechanics instruction
☐ Bed mobility instruction
☐ Instruction/use of heat
☐ Paraffin
☐ _____
_____
_____

GOALS: Rehab Potential: ☐ Good ☐ Fair

1. Patient will demonstrate increased muscle strength of_____(muscle(s)) to_____(grade) within_____weeks.
2. Patient will demonstrate increased ROM of_____(joint(s)) to_____(ROM) within_____weeks.
3. Patient will demonstrate improved sitting/standing balance to _____(grade) within_____weeks.
4. Patient will demonstrate improvement of_____transfers to _____(level of assist) within_____weeks.
5. Patient/Caregiver will demonstrate appropriate use of _____(assistive device/DME) within _____days/weeks.
6. Patient will demonstrate improved gait to_____feet with_____ _____device within_____weeks.
7. Patient will verbalize a consistent level of pain control as evidenced by a pain range to be within (scale 1-10)_____ to_____within_____weeks.
8. Patient will have improved endurance to _____(grade) within_____weeks.
9. Patient/Caregiver will be independent in home exercise program within_____weeks.
10. Patient/Caregiver will verbalize understanding of discharge plan within _____days/weeks.
11. Other: _____
_____

Therapist's Signature: _____ Date: ____/____/____

Physician's Signature: _____ Date: ____/____/____

TINETTI BALANCE ASSESSMENT TOOL

GAIT SECTION

Patient stands with therapist, walks across room (+/- aids), first at usual pace, then at rapid pace.

		Date		
Indication of gait (Immediately after told to 'go'.)	Any hesitancy or multiple attempts No hesitancy	= 0 = 1		
Step length and height	Step to Step through R Step through L	= 0 = 1 = 1		
Foot clearance	Foot drop L foot clears floor R foot clears floor	= 0 = 1 = 1		
Step symmetry	Right and left step length not equal Right and left step length appear equal	= 0 = 1		
Step continuity	Stopping or discontinuity between steps Steps appear continuous	= 0 = 1		
Path	Marked deviation Mild/moderate deviation or uses w. aid Straight without w. aid	= 0 = 1 = 2		
Trunk	Marked sway or uses w. aid No sway but flex. knees or back or uses arms for stability No sway, flex., use of arms or w. aid	= 0 = 1 = 2		
Walking time	Heels apart Heels almost touching while walking	= 0 = 1		
	Gait score		/12	/12
	Balance score carried forward		/16	/16
	Total Score = Balance + Gait score		/28	/28

Risk Indicators:

Tinetti Tool Score	Risk of Falls
≤18	High
19-23	Moderate
≥24	Low

TINETTI BALANCE ASSESSMENT TOOL

Tinetti ME, Williams TF, Mayewski R, Fall Risk Index for elderly patients based on number of chronic disabilities. Am J Med 1986:80:429-434

PATIENTS NAME _____ D.o.b. _____ Ward _____

BALANCE SECTION

Patient is seated in hard, armless chair;

		Date		
Sitting Balance	Leans or slides in chair Steady, safe	= 0 = 1		
Rises from chair	Unable to without help Able, uses arms to help Able without use of arms	= 0 = 1 = 2		
Attempts to rise	Unable to without help Able, requires > 1 attempt Able to rise, 1 attempt	= 0 = 1 = 2		
Immediate standing Balance (first 5 seconds)	Unsteady (staggers, moves feet, trunk sway) Steady but uses walker or other support Steady without walker or other support	= 0 = 1 = 2		
Standing balance	Unsteady Steady but wide stance and uses support Narrow stance without support	= 0 = 1 = 2		
Nudged	Begins to fall Staggers, grabs, catches self Steady	= 0 = 1 = 2		
Eyes closed	Unsteady Steady	= 0 = 1		
Turning 360 degrees	Discontinuous steps Continuous	= 0 = 1		
	Unsteady (grabs, staggers) Steady	= 0 = 1		
Sitting down	Unsafe (misjudged distance, falls into chair) Uses arms or not a smooth motion Safe, smooth motion	= 0 = 1 = 2		
	Balance score		/16	/16

P.T.O.