☐ 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

PHYSICAL THERAPY REVISIT NOTE

DATE OF SERVICE _____/_____/_____
TIME IN_____ **TIME OUT**_____

VITAL SIGNS: Temp:_____ Pulse:_____ Regular / Irregular Resp.:_____ B/P:_____
Using O_2 at _____LPM via:_____

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)
Pain quality:_____ (ache, sharp, etc.) Pain location:_____ Frequency:_____
Complete Briggs Pain Assessment #3459/2P per agency policy

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

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)

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
☐ Balance
☐ Modalities: ☐ TENS ☐ Ultrasound ☐ E-stim ☐ Heat ☐ Ice
☐ 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 Focused On:	Performance/Progress toward Functional Task:	Barriers towards Independence:
Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards Independence:
Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards Independence:
Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards Independence:

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_____ _____/_____/_____
Patient/Caregiver (if applicable) *Date*

Complete **TIME OUT** (above) prior to signing below.
_____ _____/_____/_____
Therapist (signature/title) *Date*

PATIENT NAME – Last, First, Middle Initial | ID#