PT Evaluation

Clinician:

Patient Name (Last Name, First Name) & MRN:	Mileage:	Gender: ☐ M ☐ F	Agency Name/Branch:

Date: / /	Time In: Time Out:	DOB: / /

HCPCS

Select the home health service type that reflects the primary reason for this visit:

- ☐ (G0151) Services Performed by a qualified physical therapist
- ☐ (G0157) Services performed by a qualified physical therapist assistant
- ☐ (G0159) Establishment or delivery of a safe and effective physical therapy maintenance program

Select the location where home health services were provided:

- ☐ (Q5001) Care provided in patient's home/residence
- ☐ (Q5002) Care provided in assisted living facility
- ☐ (Q5009) Care provided in place not otherwise specified (NO)

Diagnosis / History

Medical Diagnosis:		☐ Exacerbation	☐ Onset	/ /
PT Diagnosis:		☐ Exacerbation	☐ Onset	/ /

Relevant Medical History:	
Prior Level of Functioning:	
Patient's Goals:	
Precautions:	

Homebound? O Yes O No *clear*

- ☐ Residual Weakness
- ☐ Needs assistance for all activities
- ☐ Requires max assistance / taxing effort to leave home
- ☐ Unable to safely leave home unattended
- ☐ Severe SOB or SOB upon exertion
- ☐ Confusion, unsafe to go out of home alone
- ☐ Other:

PT Evaluation

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Social Supports / Safety Hazards

Patient Living Situation and Availability of Assistance

Patient lives:	☐ Alone	☐ Regular Daytime	☐ In congregate situation, e.g., assisted living
Assistance is available:	☐ Around the clock	☐ Occasional / short-term assistance	☐ Regular nighttime
	☐ No assistance available		

Current Types of Assistance Received (other than home health staff**)**

Safety / Sanitation Hazards

☐ No hazards indentified	☐ No running water, plumbing	☐ No gas / electric appliance
☐ Steps / Stairs:	☐ Lack of fire safety devices	☐ Pets
☐ Narrow or obstructed walkway	☐ Inadequate lighting, heating and /or cooling.	☐ Unsecured floor coverings
☐ Cluttered / soiled living area	☐ Insect / rodent infestation	

Other:

Evaluation of Living Situation, Supports, and Hazards:

Vital Signs

BP: (Prior)	Position	Side	Heart Rate:	Respirations:
Prior /	☐ Lying ☐ Sitting ☐ Standing	☐ Left ☐ Right	Prior	Prior

O2 Saturation: Prior

☐ Room Air	☐ 02 @ 3.0 lpm	☐ 02 @ 7.0 lpm	☐ 02 @ 13.0 lpm	
☐ 02 @ 0.5 lpm	☐ 02 @ 3.5 lpm	☐ 02 @ 8.0 lpm	☐ 02 @ 14.0 lpm	
☐ 02 @ 1.0 lpm	☐ 02 @ 4.0 lpm	☐ 02 @ 9.0 lpm	☐ 02 @ 15.0 lpm	
☐ 02 @ 1.5 lpm	☐ 02 @ 4.5 lpm	☐ 02 @ 10.0 lpm	☐ Other: see Comments	
☐ 02 @ 2.0 lpm	☐ 02 @ 5.0 lpm	☐ 02 @ 11.0 lpm		
☐ 02 @ 2.5 lpm	☐ 02 @ 6.0 lpm	☐ 02 @ 12.0 lpm		

Route

- via ☐ NC
- via ☐ Mask
- via ☐ Trach
- via ☐ Other: see Comments

BP: (Post)	Position	Side	Heart Rate:	Respirations:
Post /	☐ Lying ☐ Sitting ☐ Standing	☐ Left ☐ Right	Post	Post

PT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /

O2 Saturation:					Route
Post	☐ Room Air	☐ 02 @ 3.0 lpm	☐ 02 @ 7.0 lpm	☐ 02 @ 13.0 lpm	via ☐ NC
	☐ 02 @ 0.5 lpm	☐ 02 @ 3.5 lpm	☐ 02 @ 8.0 lpm	☐ 02 @ 14.0 lpm	via ☐ Mask
	☐ 02 @ 1.0 lpm	☐ 02 @ 4.0 lpm	☐ 02 @ 9.0 lpm	☐ 02 @ 15.0 lpm	via ☐ Trach
	☐ 02 @ 1.5 lpm	☐ 02 @ 4.5 lpm	☐ 02 @ 10.0 lpm	☐ Other: see Comments	via ☐ Other: see Comments
	☐ 02 @ 2.0 lpm	☐ 02 @ 5.0 lpm	☐ 02 @ 11.0 lpm		
	☐ 02 @ 2.5 lpm	☐ 02 @ 6.0 lpm	☐ 02 @ 12.0 lpm		

Comments:

Physical Assessment

Speech:		**Muscle Tone:**	
Vision:		**Coordination**	
Hearing:		**Sensation:**	
Skin:		**Endurance:**	
Edema:		**Posture:**	

Oriented: ☐ Person ☐ Place ☐ Time

Evaluation of Cognitive and/or Emotional Functioning

Pain Assessment

☐ No Pain Reported

	Location	*Intensity:**											
Primary Site:		☐ 0 None	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5 Medium	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 High	
Secondary Site:	*Location*	*Intensity:**											
		☐ 0 None	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5 Medium	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 High	

* use wong-baker scale

Increased by:	
Relieved by:	
Interferes with:	

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ROM / Strength

		ROM		Strength				ROM		Strength	
Part	***Action***	***Right***	***Left***	***Right***	***Left***	***Part***	***Action***	***Right***	***Left***	***Right***	***Left***
Shoulder	Flexion					Hip	Flexion				
	Extension						Extension				
	Abduction						Abduction				
	Adduction						Adduction				
	Int Rot						Int Rot				
	Ext Rot						Ext Rot				
Elbow	Flexion					Knee	Flexion				
	Extension						Extension				
Forearm	Pronation					Ankle	Plantar Flexion				
	Supination						Dorsiflexion				
Finger	Flexion						Inversion				
	Extension						Eversion				
Wrist	Flexion					Neck	Flexion				
	Extension						Extension				
Trunk	Extension						Lat Flexion				
	Rotation						Rotation				
	Flexion										

Comments:

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Functional Assessment

Dep	Max Assist	Mod Assist	Min Assist	CGA	SBA	Supervision	Mod Indep	Indep

Bed Mobility

	Assist Level		
Rolling		L	R

	Assistive Device
Supine - Sit	
Sit - Supine	

Deficits Due To / Comments:

Gait

	Assist Level		Distance/Amount	Assistive Device
Level		X		
Unlevel		X		
Steps/Stairs		X		

Deficits Due To / Deviations / Comments:

Transfer

	Assist Level	Assistive Device
Sit - Stand		
Stand - Sit		
Bed - Wheelchair		
Wheelchair - Bed		
Toilet or BSC		
Tub or Shower		
Car / Van		

Deficits Due To / Comments:

Wheelchair Mobility

Assist Level		Assist Level		Assist Level
Level		Unlevel		Maneuver

Deficits Due To / Comments:

Weight Bearing Status

Balance

Able to assume/maintain midline orientation

Sitting	
Standing	

Fall Risk and Other Testing

	Initial Eval Result	Re-Eval Result
Test 1		
Test 2		
Test 3		

Evaluation and Testing Description:

PT Evaluation

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Evaluation Assessment

Evaluation Assessment Summary

Functional Limitations

☐ Decreased ROM / Strength ☐ Impaired Balance / Gait ☐ Increased Pain ☐ Decreased Wheelchair Mobility

☐ Poor Safety Awareness ☐ Decreased Transfer Ability ☐ Decreased Bed Mobility

Comments:

Short-Term Treatment Goals

		Target Date
1:		/ /
2:		/ /
3:		/ /
4:		/ /
5:		/ /
6:		/ /
7:		/ /
8:		/ /
9:		/ /
10:		/ /

PT Evaluation

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Long-Term Treatment Goals

		Target Date
1:		/ /
2:		/ /
3:		/ /
4:		/ /
5:		/ /
6:		/ /
7:		/ /
8:		/ /
9:		/ /
10:		/ /

☐ No Changes to Plan of Care: Physician signature is not required if no change to Plan of Care for therapy reassessment visit

Treatment Plan

☐ Thera Ex
☐ Hip Precaution Training
☐ Establish or Upgrade HEP
☐ Knee Precaution Training
☐ Transfer Training
☐ Pulmonary Physical Therapy
☐ Gait Training
☐ Range of Motion
☐ Balance Training
☐ Muscle Re-education
☐ Bed Mobility Training
☐ Ultrasound
☐ Prosthetic Training
☐ Electrotherapy
☐ Stairs / Steps Training
☐ O_2 Sat Monitoring PRN
☐ Home Safety Training
☐ Assistive Device Training (specify):
☐ Modalities for Pain Control (specify):
☐ CPM (specify):
☐ Other (specify):

Comments:

PT Evaluation

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Care Coordination

Conference With

☐ PT ☐ PTA ☐ OT ☐ COTA ☐ ST ☐ SN ☐ Aide ☐ Supervisor Other:

Name(s):

Regarding:

☐ Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction

Other Discipline Recommendations: ☐ OT ☐ ST ☐ MSW ☐ Aide

Other:

Reason:

Statement of Rehab Potential

Treatment / Skilled Intervention This Visit

Frequency and Duration

	Start Date	End Date	Effective Date	Frequency
Current Episode:	/ /	/ /	/ /	
Next Episode:	/ /		/ /	

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Discharge Plan

☐ To self care when goals met ☐ To self care when max potential achieved ☐ To outpatient therapy with MD approval

☐ Other:

Signature and Title: **Date: / /**