PT Visit

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)

Health Status

Medical Diagnosis:

PT Diagnosis:

Homebound? O Yes O No

- ☐ 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:

Vital Signs

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

O2 Saturation:					**Route**
Prior	☐ 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		

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

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	/ /

O2 Saturation:					Route
During	☐ 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		

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

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		

Mid-Treatment Vital Changes:

Comments:

Current Treatment Plan

Evaluation Date: / /

Evaluation clinician:

Treatment Plan:

Subjective Evaluation

Subjective Evaluation and Observations

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Pain Assessment

☐ No Pain Reported at Visit

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

** wong-baker scale*

Increased by:	
Relieved by:	
Interferes with:	

Objective Evaluation and Training / Interventions

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

Bed Mobility Training

	Assist Level	Assistive Device	Training / Intervention
Rolling		☐ L ☐ R	
Supine - Sit			
Sit - Supine			

Deficits Due To / Comments:

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Transfer Training

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

Deficits Due To / Comments:

Gait Training

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

Deficits Due To / Comments:

Weight Bearing Status	Training / Intervention

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Other Training

Wheelchair Mobility

	Assist Level		Assist Level		Assist Level	Training / Intervention
Level		Unlevel		Maneuver		

Deficits Due To / Comments:

Posture **Training / Intervention**

Balance ☐ Able to assume/maintain midline orientation

	Assist Level			
Sitting		☐ Supported ☐ Unsupported	Verbal Cues	
Standing		Assistive Device: ☐ With ☐ Without	Tactile Cues	

Fall Risk and Other Testing

Previous Follow Up Result

Test 1	
Test 2	
Test 3	

Follow Up Testing and Training:

Training Exercises

☐ Therapeutic Exercises ☐ ROM ☐ Active ☐ Active / Assistance ☐ Resistive, w/weights ☐ Stretching ☐ Other

Exercise Description(s)

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Assessment

Teaching

	Verbalized Understanding		Demonstrated Understanding		Comments
☐ Home Exercise Program:	☐ Patient	☐ Caregiver	☐ Patient	☐ Caregiver	
☐ Safe Transfer:	☐ Patient	☐ Caregiver	☐ Patient	☐ Caregiver	
☐ Safe Gait:	☐ Patient	☐ Caregiver	☐ Patient	☐ Caregiver	
Required Further Teaching:	☐ Patient	☐ Caregiver			

Title(s) of Teaching Tool(s) Used/Given:

Current Treatment Goals

Evaluation Date: / /

Evaluation clinician:

Treatment Goals:

Progress to Goals

☐ Progress to goals indicated by:

☐ Needs continued skilled PT to address:

☐ Progress delayed due to:

☐ Other:

Additional Narrative Summary

Functional Limitations

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

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

Comments:

Plan

☐ Skilled progress for next visit:

☐ Physician contacted to review / update orders

☐ Discharge Planning:

☐ Written notice of discharge provided to patient

Care Coordination

Conference with:

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

☐ Names:

☐ Regarding
:

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

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