PT Visit with Supervisory 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: Prior

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

Route

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

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

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O2 Saturation: During					**Route**
	☐ 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	via ☐ NC
	☐ 02 @ 1.0 lpm	☐ 02 @ 4.0 lpm	☐ 02 @ 9.0 lpm	☐ 02 @ 15.0 lpm	via ☐ Mask
	☐ 02 @ 1.5 lpm	☐ 02 @ 4.5 lpm	☐ 02 @ 10.0 lpm	☐ Other: see Comments	via ☐ Trach
	☐ 02 @ 2.0 lpm	☐ 02 @ 5.0 lpm	☐ 02 @ 11.0 lpm		via ☐ Other: see Comments
	☐ 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: Post					**Route**
	☐ 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	via ☐ NC
	☐ 02 @ 1.0 lpm	☐ 02 @ 4.0 lpm	☐ 02 @ 9.0 lpm	☐ 02 @ 15.0 lpm	via ☐ Mask
	☐ 02 @ 1.5 lpm	☐ 02 @ 4.5 lpm	☐ 02 @ 10.0 lpm	☐ Other: see Comments	via ☐ Trach
	☐ 02 @ 2.0 lpm	☐ 02 @ 5.0 lpm	☐ 02 @ 11.0 lpm		via ☐ Other: see Comments
	☐ 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	☐ 2	☐ 4	☐ 6	☐ 8	☐ 10 High
			☐ 1	☐ 3	☐ 5 Medium	☐ 7	☐ 9	
		*Post-Therapy Intensity:**	☐ 0 None	☐ 2	☐ 4	☐ 6	☐ 8	☐ 10 High
			☐ 1	☐ 3	☐ 5 Medium	☐ 7	☐ 9	
Secondary Site:	*Location*:	*Pre-Therapy Intensity:**	☐ 0 None	☐ 2	☐ 4	☐ 6	☐ 8	☐ 10 High
			☐ 1	☐ 3	☐ 5 Medium	☐ 7	☐ 9	
		*Post-Therapy Intensity:**	☐ 0 None	☐ 2	☐ 4	☐ 6	☐ 8	☐ 10 High
			☐ 1	☐ 3	☐ 5 Medium	☐ 7	☐ 9	

** 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		Training / Intervention
Rolling		☐ L ☐ R	
		Assistive Device	
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:

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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:

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Supervisory Assessment

Supervision Date	/ /			
Supervisor Name:				
Clinician Name:				
Clinician Present at time of Visit:	O Yes O No			
Score	**Excellent**	**Satisfactory**	**Unsatisfactory**	**Unknown**
Notifies client/caregiver of schedule:	O	O	O	O
Reports for duty as assigned:	O	O	O	O
Cooperative with client and others:	O	O	O	O
Courteous toward client and others:	O	O	O	O
Follows client care plan as instructed:	O	O	O	O
Documents appropriately:	O	O	O	O
Timely notification to supervisor of client's needs or changes in condition:	O	O	O	O
Adheres to organizational policies and procedures				

Changes and/or instructions:

Comments:

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