PT Evaluation / Re-evaluation

Clinician:

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

☐ Patient identity confirmed by clinician

Gender: ☐ M ☐ F

DOB: / /

Agency Name/Branch:

Date: / / **Time In:** **Time Out:** **Associated mileage:** *miles*

Diagnosis/History

Medical Diagnosis: ☐ Onset ☐ Exacerbation Date: / /

PT Diagnosis: ☐ Onset ☐ Exacerbation Date: / /

Relevant Medical History:

Prior Level of Functioning:

Patient's Goals: **Precautions:**

Functional Limitations:

☐ ROM/Strength ☐ Balance/Gait ☐ Pain ☐ Safety Techniques ☐ Transfer ☐ Bed Mobility ☐ W/C Mobility

Comments:

Homebound? ○ Yes ○ No

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

Social Supports / Safety Hazards

Patient Living Situation and Availability of Assistance

Patient lives: ○ alone ○ with other person(s) in the home ○ in congregate situation, e.g., assisted living

Assistance is available: ○ around the clock ○ regular daytime ○ regular nighttime ○ occasional/short-term assistance ○ no assistance available

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

Safety / Sanitation Hazards

☐ No hazards identified
☐ Steps/stairs
☐ Narrow or obstructed walkway
☐ Cluttered/soiled living area
☐ No running water, plumbing
☐ Lack of fire safety devices
☐ Inadequate lighting, heating and/or cooling
☐ Insect/rodent infestation
☐ No gas/electric appliance
☐ Other *(specify):*

Evaluation of Living Situation, Supports, and Hazards

Vital Signs

	BP:	Heart Rate:	Respirations:	O2 Sat:			
Prior:					○ Room Air	○ O2 @	via
Post:					○ Room Air	○ O2 @	via

Comments:

Physical Assessment

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

Oriented: ☐ Person ☐ Place ☐ Time

Evaluation of Cognitive and/or Emotional Functioning

Pain Assessment

☐ No Pain Reported

	Location	Intensity *(0 None - 10 High)*
Primary Site:		
Secondary Site:		

Increased by:

Relieved by:

Interferes with:

		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:

Functional Assessment

Independence Scale Key Dep | Max Assist | Mod Assist | Min Assist | CGA | SBA | Supervision | Mod Indep | Indep

Bed Mobility	**Assist Level**	**Assistive Device**	**Gait**	**Assist Level**		**Distance/Amount**	**Assistive Device**
Rolling: ☐ L ☐ R			Level		x		
Supine - Sit			Unlevel		x		
Sit - Supine			Step/Stairs		x		
Comments:			Deviations/Comments:				

Transfer	Assist Level	Assistive Device
Sit - Stand		
Stand - Sit		
Bed - W/C		
W/C - Bed		
Toilet or BSC		
Tub or Shower		
Car / Van		
Comments:		

Other

W/C Mobility	Assist Level
Level	
Unlevel	
Maneuver	
Comments:	
Weight Bearing Status:	

Balance

☐ Able to assume/maintain midline orientation

	Assist Level
Sitting	
Standing	

Evaluation & Testing Description

Fall Risk Testing

	Result
Test 1	
Test 2	
Test 3	

Common fall risk tests include: *Tinetti, Functional Reach, Timed Up & Go, One Leg Standing - Left, One Leg Standing - Right, 4 Square Step, 3 Meter Walk Test, Berg Balance, and Gait Velocity.*

DME

Available: ☐ W/C ☐ Walker ☐ Hospital Bed ☐ Bedside Commode ☐ Raised Toilet Seat ☐ Tub/Shower Bench

Other:

Needs:

Evaluation Assessment & Skilled Intervention Plan

Treatment Goals

		Time Frame
1:		
2:		
3:		
4:		
5:		
6:		
7:		

Treatment Plan

- ☐ Thera Ex
- ☐ Establish or Upgrade HEP
- ☐ Transfer Training
- ☐ Gait Training
- ☐ Balance Training
- ☐ Bed Mobility Training
- ☐ Prosthetic Training
- ☐ Stairs/Steps Training
- ☐ Home Safety Training
- ☐ Hip Precaution Training
- ☐ Knee Precaution Training
- ☐ Pulmonary Physical Therapy
- ☐ Range of Motion
- ☐ Muscle Re-education
- ☐ Ultrasound
- ☐ Electrotherapy
- ☐ O2 Sat Monitoring PRN
- ☐ Assistive Device Training (specify):
- ☐ Modalities for Pain Control (specify):
- ☐ CPM (specify):
- ☐ Other (specify):

Care Coordination

Conference with:

☐ PTA ☐ OT ☐ COTA ☐ SN ☐ Supervisor ☐ Other:

Name(s):

Regarding:

☐ Reviewed Plan of Care, Goals, Frequency, and Direction

Other Discipline Recommendations

☐ OT ☐ ST ☐ MSW ☐ Aide ☐ Other:

Reason:

Statement of Rehab Potential

Treatment / Skilled Intervention This Visit

Frequency & Duration

	Start Date	**End Date**
Current Certification Period:		

Effective Date	Frequency

	Expected Start Date	**Expected Frequency**
Next Certification Period:		

Discharge Plan

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

☐ Other:

Therapist Signature, Name & Date of Verbal Order for Start of PT Treatment **Date:** / /

Physician Name **Physician Phone:**

Physician Signature **Physician Fax:**

Date: / /