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Chart: 3 Episode: 1 Therapy Visit #:

1

Travel Time: minutes

Chart Time: 30 minutes

Mileage: 0

Billing Code: PTE - PT Initial Eval Visit

Time In: 4:42 PM

Time Out: 5:16 PM

Agency S.O.C. Date 05/13/2025

☐ SOC☐ Recert☐ ROC

PHYSICAL THERAPY EVALUATION

PT Evaluation Date 05/19/2025

Birth Date 6/2/1956

Reason for Physical Therapy Referral MD ORDER: "Physical therapy evaluation and treatment as indicated to weakness, difficulty ambulating and recent fall."

Prior Functional Status Independent with all mobilities

Other Pertinent Diagnoses/Medical History: psoriasis, COPD, current smoker, dementia, depression, anxiety, cognitive dysfunction, HTN

Physician's Name (First): Hany (Last): Mistikawy

Physician's Phone #: (508) 679-2265

MUSCULOSKELETAL STATUS / PHYSICAL THERAPY ASSESSMENT

VITAL SIGNS: PULSE: ☐ Apical ☐ (Reg) ☐ (Irreg) Height B/P Lying Sitting Standing
(per agency policy) ☒ Radial 78 ☐ (Reg) ☐ (Irreg) Weight L 132/78
TEMP: 97.7 RESP: 17 ☐ Actual ☐ Stated R
Current Weight Bearing Status: FWB

ADL's	Independent	Req. Assistance	Dependent	I	RA	D		I	RA	D	
	I	RA	D								
Grooming	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bathing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Ambulation/Locomotion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Ability to Dress Upper Body	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Toileting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Feeding or Eating	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Dress Lower Body	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Transferring	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Light Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
								Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
								Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
								Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
								Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
								Ability to Use Telephone	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

RANGE OF MOTION / MOBILITY

Joint/ Segment	Movement	Range	PROM		AROM		Joint/ Segment	Movement	Range	PROM		AROM		Joint/ Segment	Movement	Range	PROM		AROM	
			Right	Left	Right	Left				Right	Left	Right	Left				Right	Left	Right	Left
Elbow	Flexion	0-140					Shoulder	Flexion	0-180					Knee	Flexion	0-120				
	Hyperextension	0-0						Abduction	0-180						Extension	0-15				
Forearm	Pronation	0-90					Hip	Other:						Ankle	Flexion	0-45				
	Supination	0-90						Flexion	0-120						Extension	0-30				
Wrist	Extension	0-70						Extension	0-25					Cervical Spine	Flexion	0-45				
	Flexion	0-70						Adduction	0-45						Hyperextension	0-45				
	Radial Deviation	0-70						Abduction	0-45						Lateral Flexion	0-45				
	Ulnar Deviation	0-70						Internal Rot.	0-45						Rotation	0-45				
								External Rot.	0-45											

Comments

MUSCLE STRENGTH AGAINST GRAVITY

Strength Scale: 5 = WNL 4 = Good 3 = Fair 2 = Poor 1 = Trace 0 = Absent

☒ LUE: ☐ 5 ☐ 4 ☐ 3
☐ 2 ☐ 1 ☐ 0

☒ RUE: ☐ 5 ☐ 4 ☐ 3
☐ 2 ☐ 1 ☐ 0

☒ LLE: ☐ 5 ☐ 4 ☐ 3
☐ 2 ☐ 1 ☐ 0

☒ RLE: ☐ 5 ☐ 4 ☐ 3
☐ 2 ☐ 1 ☐ 0

☒ Left Hand: ☐ 5 ☐ 4 ☐ 3
☐ 2 ☐ 1 ☐ 0

☒ Right Hand: ☐ 5 ☐ 4 ☐ 3
☐ 2 ☐ 1 ☐ 0

Comments

TRANSFERS

KEY: 5 = Maximum Assist 3 = Minimum Assist 1 = Independent AD = With Assistive Device
4 = Moderate Assist 2 = Standby Assist W/O AD = Without Assistive Device

☒ Bed Mobility 1 ☐ Chair 2
☐ AD ☐ W/O AD ☒ AD ☐ W/O AD

☒ In/Out of Bed 1 ☐ Commode/Toilet 2
☐ AD ☐ W/O AD ☐ AD ☐ W/O AD

☒ Sit to Stand 2 ☐ Tub/Shower 2
☐ AD ☐ W/O AD ☐ AD ☐ W/O AD

Performance Affected By:

Unsteady

BALANCE/GAIT

Physician: Dr. Mistikawy, Hany A.

Clinician: clinician, Agency

Signature:

Signature:

Date: 6/3/2025

Date: 5/19/2025

Electronically signed by Dr. Mistikawy, Hany A. on 6/3/2025



SITTING <input type="checkbox"/> NO DEFICIT <input type="checkbox"/> Describe: ALTERED	BALANCE/ GAIT Berg Score: Tinetti score = 19/28 indicating that patient is a fall risk, CRT = 4, 4 stage balance testing = 2/4, TUGS = 24s Tinetti Score: Other:	Comments
STANDING <input type="checkbox"/> NO DEFICIT <input checked="" type="checkbox"/> Describe: Unequal ALTERED	GAIT <input type="checkbox"/> SHUFFLING <input checked="" type="checkbox"/> UNSTEADY <input type="checkbox"/> TREMORS Gait Surfaces: (Indicate highest level of function) <input type="radio"/> 4 - Navigates various surfaces without assistive device <input checked="" type="radio"/> 3 - Navigates various surfaces with assistive device <input type="radio"/> 2 - Navigates flat surfaces without assistive device <input type="radio"/> 1 - Navigates flat surfaces with assistive device <input type="radio"/> 0 - Unable to navigate flat surfaces with or without assistive device Gait Surface Score: Gait Distance/Speed: Distance: 80ft ft per sec/min <input checked="" type="checkbox"/> With assistive device <input type="checkbox"/> Without assistive device Speed for 1 meter:	ENDURANCE <input checked="" type="checkbox"/> With assistive device <input type="checkbox"/> Without assistive device <input type="checkbox"/> 0 - Not troubled with breathlessness except with strenuous exercise <input type="checkbox"/> 1 - Troubled by shortness of breath when hurrying on level surface or walking up a slight hill <input type="checkbox"/> 2 - Walks slower than people of the same age on level surface because of breathlessness or has to stop for a breath when walking at own pace on level surface <input type="checkbox"/> 3 - Usually too breathless to leave the house or breathless when dressing or undressing Endurance Score: Comments
Comments	PSYCHOSOCIAL/EMOTIONAL STATUS/WHICH MAY IMPACT PLAN OF CARE <input checked="" type="checkbox"/> None <input type="checkbox"/> Identified as Comments	COGNITIVE BEHAVIORS THAT MAY IMPACT CARE <input checked="" type="checkbox"/> None <input type="checkbox"/> Identified as Comments
JOINTS <input type="checkbox"/> No Deficit <input type="checkbox"/> Enlarged <input type="checkbox"/> Warm/Red <input type="checkbox"/> Stiff <input type="checkbox"/> Painful Comments	HOME STRUCTURE / HOUSEHOLD BARRIERS THAT MAY IMPACT PLAN OF CARE <input checked="" type="checkbox"/> None <input type="checkbox"/> Identified as Comments	
PROSTHETIC DEVICE/ADAPTIVE EQUIPMENT <input type="checkbox"/> None <input checked="" type="checkbox"/> Cane due to: Unsteady <input type="checkbox"/> Cast/Splint due to: <input checked="" type="checkbox"/> Walker due to: Unsteady <input type="checkbox"/> Prosthesis due to: <input type="checkbox"/> Other: <input type="checkbox"/> Adaptive Device due to: Comments		
SENSORY EFFECTS ON THERAPY <input type="checkbox"/> Vision <input type="checkbox"/> Vertigo <input type="checkbox"/> Medications <input type="checkbox"/> Impaired Cognition <input type="checkbox"/> Other: Comments		
NEUROLOGICAL <input checked="" type="checkbox"/> WNL	SENSATION <input checked="" type="checkbox"/> WNL	PALPATION <input type="checkbox"/> Not Tested Location:
SKIN CONDITION <input checked="" type="checkbox"/> WNL	EDEMA <input checked="" type="checkbox"/> WNL	



Form# HC1013H-DV

(Rev. 10/17)

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This form has been electronically signed by:

Plante, Mike (PT) PT 05/19/2025 04:59:42 PM EDT

Physician: Dr. Mistikawy, Hany A. (MD (Dr. Alliance))

Clinician: clinician, Agency

Signature:

Signature:

Date: 6/3/2025

Date: 5/19/2025

Electronically signed by Dr. Mistikawy, Hany A. on 6/3/2025



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Chart: 3 Episode: 1 Therapy Visit #:

PAIN Frequency of Pain interfering with patient's activity or movement: <input checked="" type="radio"/> 0-Patient has no pain <input type="radio"/> 1-Patient has pain that does not interfere with activity or movement <input type="radio"/> 2-Less often than daily <input type="radio"/> 3-Daily, but not constantly <input type="radio"/> 4-All of the time	PAIN PROFILE Primary Site Current pain management & effectiveness: <input type="checkbox"/> Pain Management Teaching to patient/family (document below) Patient's pain goal: Progress toward pain goal:	<input type="checkbox"/> See Additional Pain Assessment/ Documentation (per agency policy) Refer to Intensity: No Hurt Hurts Little Bit Hurts Little More Hurts Even More Hurts Whole Lot Hurts Worst WONG-BAKER FACES¹ PAIN RATING SCALE ¹ From Hockenberry MJ, Wilson D: Wong's Essentials of Pediatric Nursing , ed. 8, St. Louis, 2009 Mosby. Used with permission. Copyright Mosby.
Comments		

HOMEBOUND

Eligibility

HOMEBOUND STATUS:

Patient is NOT HOMEBOUND. Please be advised, patient is not confined to place of residence. Patient goes out independently for errands, social reasons, and leisure activities, and does so routinely without any taxing effort. Services are medically necessary. Start Effective Date: 05/14/2025

ANY ADDITIONAL PROBLEMS IDENTIFIED**PHYSICAL THERAPY ORDERS****Frequency/Duration of PT Visits:** PT/PTA: 2 x week for 4 weeks starting 05/19/2025 (week 2)**Additional Disciplines for Evaluation:** ☐ SN ☐ OT ☐ SLP ☐ MSS ☐ OTHER: _____☐ Home Health Aide added to assist w/personal care/ADLs/light housekeeping as needed Visit Frequency/Duration: _____

Interventions

PT TREATMENT PLAN:

Balance Training Start Effective Date: 05/19/2025

Functional mobilities Start Effective Date: 05/19/2025

Gait Training Start Effective Date: 05/19/2025

Home Program Establish/Upgrade Start Effective Date: 05/19/2025

Muscle re-education Start Effective Date: 05/19/2025

Patient/Caregiver/Family Education in fall prevention strategies, energy conservation strategies, home exercise program Start Effective Date: 05/19/2025

Teach Pt/Pcg: Safe, effective use of adaptive/assist device Start Effective Date: 05/19/2025

Teach safety precautions Start Effective Date: 05/19/2025

Therapeutic Exercise Start Effective Date: 05/19/2025

Transfer Training Start Effective Date: 05/19/2025

GOALS / REHABILITATION POTENTIAL / DISCHARGE PLAN

Goals

PT SHORT TERM AND LONG TERM GOALS:

Ambulation endurance will be 300+ feet within duration of certification period Start Effective Date: 05/19/2025

Demonstrates ability to follow home exercise program within duration of certification period Start Effective Date: 05/19/2025

Increase strength of R / L LE to 4+ / 5 within duration of certification period Start Effective Date: 05/19/2025

Independent with ambulation with cane household/ facility/ community distances within duration of certification period Start Effective Date: 05/19/2025

Independent with safety issues/ fall prevention strategies within duration of certification period Start Effective Date: 05/19/2025

Independent with transfer skills within duration of certification period Start Effective Date: 05/19/2025

Pt will be able to negotiate entrance ramp/uneven surfaces with cane within duration of certification period Start Effective Date: 05/19/2025

Pt will have an increase in Tinetti balance score from 19/28 to 24/28 within duration of certification period Start Effective Date: 05/19/2025

Rehab Potential

PT REHAB POTENTIAL:

Physician: Dr. Mistikawy, Hany A.

Clinician: clinician, Agency

Signature:

Signature:

Date: 6/3/2025

Date: 5/19/2025

Electronically signed by Dr. Mistikawy, Hany A. on 6/3/2025



PT Rehab Potential: Good Start Effective Date: 05/19/2025

Discharge Planning

PT DISCHARGE PLAN:

Patient will be discharged from PT when functional goals are met or maximized Start Effective Date: 05/19/2025

CARE COORDINATION

- ☐ Patient, Caregiver and/or Representative (if any) agreed with and participated in the POC
☒ Physician contacted with assessment findings and approved orders, discipline and frequency

Conferenced With: ☒ SN ☐ PT ☐ OT ☐ SLP ☐ MSW ☐ HHA

Name(s): Melissa, Sarah

Regarding: PT POC

Skilled Services provided this visit and Patient Response:

PT EVALUATION: This patient is an alert and oriented x 3 (forgetful) 68 old female who was referred to homecare PT following hospitalization at SAH hospitalized at SAH on 4/24/25- 4/30/25 after fall next to her bed , pt reports " I was on the floor for 5 hours , I couldn't get up", transferred to Mill Brook for short term rehab, pt returned home 5/13/25. Pt presents with increased weakness BLE pt reports R knee buckling at times, increased difficulty with all mobilities. Pt reports no pain, no new falls . She wishes PT to " get rid of these (Rollator, cane), they gave me them at the hospital, I'd rather not have to use them"

Pt lives at ALF @ GABRIAL HOUSE

pts personal goal is to improve ability to walk, improve strength BLE

She lives in ALF, large / long ramp to enter. Staff asst with care/ ADLs.

PLOF: Pt was able to ambulate to/ from dining room with no AD independently , ambulated indoors/ outdoors independently

PMH: psoriasis, COPD, current smoker, dementia, depression, anxiety, cognitive dysfunction, HTN

PAIN: pt reports no pain

Currently

BED MOBILITY: independent

TRANSFERS: Requires SBA with household transfers, w/ cane (declines use of Rollator, which was reintroduced and encouraged to use) , min cues / ongoing training needed for alignment, positioning, fall prevention strategies..

GAIT: Pt ambulated 80 ft, 50ft in hallway with SBA with cane , balance worsens with distance , +SOB, quickly fatigues, ongoing training/ mod cues needed for proper stepage, safe turning, proper sequencing, fall prevention strategies.

ENTRANCE RAMP: pt deferred

LLE strength =-4/5 throughout, RLE Strength =- -4/5

Activity tolerance = fair

BALANCE : Tinetti score =19/28 indicating that patient is a fall risk, CRT = 4, 4 stage balance testing = 2/4, TUGS = 24s

EDUCATION COMPLETED : energy conservation strategies, proper use of AD, fall prevention strategies , pt with good response to education, however ongoing training, reinforcement needed.

Pt will benefit from further skilled physical therapy 2x/week for 4 weeks for gait training, therapeutic exercises and activities, neuromuscular re-education, patient education.

Pt agrees with poc, called PCP Dr Mistikawy office , poc approved via verbal order

MICHAEL PLANTE PT 17911

CHECK ONE: ☒ G0151-PT ☐ G0159-PT Maintenance

Physician's Signature/Date (optional per agency policy):

Date:

Form# HC1013H-DV

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Patient's Signature

Signed on 05/19/2025 05:00:56 PM EDT

Physician: Dr. Mistikawy, Hany A.

Clinician: clinician, Agency

Signature:

Signature:

Date: 6/3/2025

Date: 5/19/2025

Electronically signed by Dr. Mistikawy, Hany A. on 6/3/2025