VISIT DATE: 10-30-2019

DOB: | **PHYSICAL THERAPY - Discharge** | **Time In/out:** 01:00-02:06 AM

Patient Name: 101 101
Primary Dx: This is a Primary Diagnos
Therapy Dx: Therapy Diagnosis
Physician: ALFREDO LASSERRE, MD

Medicaid T #: 12123
Dx Date: 07-21-2016
Dx Date: 07-22-2016
Clinician: Ruben Neira

Medical Rec#:
SOC: 05-01-2016
From: 10-13-2019
☑ **Recertif.**
To: 12-11-2019

Assessment Type: Discharge
Billable ☐ No ☑ Yes **Therapy Type:** ☑ Restorative ☐ Maintenance

Subjective / Objective / Hx:

PHYSICAL ASSESSMENT

JOINT ACTION	STRENGTH L	STRENGTH R	R.O.M L	R.O.M R
HIP				
Abduction	3+/5	1+/5		
Adduction	4-/5	1+/5		
Rotation	3+/5	1+/5		
Flexion	3+/5	1+/5		
Extension	3+/5	1+/5		
KNEE				
Flexion	3+/5	1+/5		
Extension	3+/5	1+/5		
ANKLE				
Dorsiflex / Plantar Flex	3+/5	1+/5		
Inversion / Eversion	3+/5	1+/5		
TRUNK				
PART/ACTION	**STRENGTH L**	**STRENGTH R**	**R.O.M L**	**R.O.M R**
SHOULDER				
Flexion	2+/5	2/5		
Extension	2+/5	2/5		
Abduction	2+/5	2/5		
Adduction	2+/5	2/5		
ELBOW				
Flexion	2+/5	2/5		
Extension	2+/5	2/5		
Wrist/Grip	2+/5	2/5		

FUNCTIONAL STATUS

	Previous	Current
Bed Mobility		SBA-SUP
Transfers W/C		Max
Transfers Tub/Shower		Min
Supine to Sit		Max
Sit to stand		Max
Gait		Max Ft
Gait Device Type		
Weight Bearing Status	☐ R LE ☐ L LE	☐ R LE ☐ L LE

Other:

Stairs	Max
Steps / Curb	Max
Toileting	Max
Wheelchair Mgmnt	Max
Other	Max

BALANCE

☑ **Tinetti Score** ☐ N/A ☐ NT
Gait ____ Balance ____ Total ____
☐ Berg ☐ N/A ☐
Note:

☐ TUG ☐ N/A ☐ NT
Note:

BALANCE ASSISST

Static Sitting ____
Dynamic Sitting ____
Dynamic Standing ____

Note: unlike other monolithic fra meworks, vue is designed from the

POSTURE

Sitting Posture ____
Standing Posture ____
Transitional ____

Note:

GAIT / DISTANCE / SURFACE

SYSTEMS ASSESSMENT

BP: / ☐ R ☐ L
☐ Sitting ☐ Lying ☐ Standing
HR: **O2 Sat %:** **Resp:**
TEMP:
Skin:

PAIN ASSESSMENT

☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Location:
Pain Control:

Time since last medication:

MENTAL STATUS

☐ Alert ☐ Oriented
☐ Disoriented ☐ Forgetful
☐ Agitated ☐ Depressed

HOME EVALUATION

☐ Alone
Other:

☐ Home ☐ Apt
☐ Mobile Home ☐ Stairs
☐ Senior Complex
☐ Spacious ☐ Clean
☐ Crowded ☐ Cluttered
☐ Unsound Structure
☐ No Telephone available or unusable

SAFETY MEASURES

☐ Clear Pathways ☐ Fall Precaution
☐ Safety at home
☐ Emergency Management
☐ Ortho Precautions / Restrictions
☐ Steps
☐ Stairs
☐ 24 hr. supervision
☐ Infection control measures
☐ Use DME Equipment:

OTHER ASSESSMENTS:

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EQUIPMENT IN THE HOME

☐ Tub ☐ Shower Bench ☐ Handheld Shower ☐ Reacher ☐ Wheelchair ☐ Hospital Bed
☐ Bedside Comm ☐ Raised Toilet Seat ☐ Grab Bars Toilet ☐ Grab Bars Bath
☐ Grab Bars Shower ☐ Walker ☐ Rolling Walker ☐ Cane ☐ Other:

THERAPY INTERVENTION / INSTRUCTION

☐ Evaluation ☐ Lymphedema ☐ Chest Physiotherapy ☐ Ultrasound ☐ Home Exercise Program ☐ Therapeutic Exercise
☐ Electrotherapy ☐ Muscle Reeduc ☐ Balance ☐ Gait Training ☐ Transfer Training ☐ Prosthetic Training
☐ Fabrication of Devices
☐ Other:

FUNCTIONAL LIMITATIONS / PROBLEM AREAS

☐ Amputation ☐ Ambulation ☐ Hearing
☐ Bowel Bladder Incontinence ☐ Speech ☐ Legally Blind
☐ Contracture ☐ Endurance ☐ Paralysis
☐ Dyspnea w/min exertion ☐ Poor Conditioning
☐ Decreased Range of Motion ☐ Impaired Functional Strength
☐ Shuffling/wide based Gait ☐ Impaired Functional Mobility
☐ Dysfunctional Posture ☐ Impaired Transfer Technique
☐ Impaired Safety Awareness ☐ Impaired Balance
☐ Soft Tissue spasm/restriction/Edema
☐ Impaired Coordination ☐ Pain Restricting Activity
☐ Swollen painful joints (specify): _____
☐ Other:

PLAN OF CARE

☐ Evaluation ☐ Lymphedema ☐ Chest PT
☐ Ultrasound Treatment ☐ Gait Training ☐ Balance Training
☐ Home Exercise Program ☐ Electrotherapy
☐ Therapeutic Exercise ☐ Muscle Re-Education
☐ Transfer Training ☐ Prosthetic Training
☐ Pulse Oximetry Prn ☐ Home Safety ☐ Fall Prevention
☐ Modality (specify frequency, duration, amount): _____
☐ Other:
☑ Discharge

SHORT TERM AND LONG TERM GOALS WITH TIME FRAMES

	Met By	Date
☐ Return to pre-injury / illness level of function within: _____	Met _____	Date _____
☐ Patient will meet maximum potential within: _____	Met _____	Date _____
☐ Return to optimal and safe functionality within: _____	Met _____	Date _____
☐ Demonstrate effective pain management within: _____	Met _____	Date _____
☐ Improve bed mobility to: _____ assist within: _____	Met _____	Date _____
☐ Improve bed mobilty to independent within: _____	Met _____	Date _____
☐ Improve transfers to _____ assist using _____ within: _____	Met _____	Date _____
☐ Independent with transfer skills within: _____	Met _____	Date _____
☐ Pt-Cg to be independent with safety issues in: _____	Met _____	Date _____
☐ Improve wheelchair use to: _____ within: _____	Met _____	Date _____
☐ Patient will ambulate with _____ device with _____ assist within _____	Met _____	Date _____
☐ Pt will be able to climb stairs _____ device with _____ assist within _____	Met _____	Date _____
☐ Independent with ambulation with: _____ assist within: _____	Met _____	Date _____
☐ Ambulation endurance will be: _____ minutes or _____ feet within: _____	Met _____	Date _____
☐ Increase strength of extremity: _____ within: _____	Met _____	Date _____
☐ Increase strength of extremity: _____ within: _____	Met _____	Date _____
☐ Increase ROM of _____ joint to _____ degree flexion and _____ degree ext. within: _____	Met _____	Date _____
☐ Increase ROM of _____ joint to _____ degree of _____ within: _____	Met _____	Date _____
☐ Demonstrate ROM to WNL within: _____	Met _____	Date _____
☐ Demonstrate proper use of ☐ Prosthesis ☐ Brace ☐ Splint within: _____	Met _____	Date _____
☐ Demonstrate proper use of DME within: _____	Met _____	Date _____
☐ Patient will have an increase in Tinetti Balance score to: _____ /28 within: _____	Met _____	Date _____
☐ Improve balance score to: _____ using _____ test.	Met _____	Date _____
☐ Pt-Cg will demonstrate ability to follow home exercise program by: _____	Met _____	Date _____
☐ Other: _____ within: _____	Met _____	Date _____
☐ Other: _____ within: _____	Met _____	Date _____
☐ Other: _____ within: _____	Met _____	Date _____
☐ Other: _____ within: _____	Met _____	Date _____

REHAB POTENTIAL

☐ Excellent ☐ Good ☐ Fair ☐ Poor

FREQUENCY/DURATION

_____

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☑ **Discharge from PT Reason:** ☐ Reached maximal benefit from therapy ☐ Goals Met ☑ Patient request ☐ MD Request
☐ Patient Transferred ☐ Other asdfasdfsadfa

DISCHARGE PLANS:
☐ Return to an independent level of self care ☐ Able to remain in residence with assist. of primary cg / support from community agencies
☐ When maximum functional potential reached ☐ Able to understand care related to Diagnosis ☐ Other:
☐ Patient / Caregiver participated in plan of care ☐ Patient is OK with family involvement with care

HOME BOUND STATUS
☐ Considerable & taxing effort to leave home ☐ Requires assistance to ambulate
☐ Residual weakness ☐ Dependent upon adaptive device(s)
☐ Confusion, unable to go out alone
☐ Other:

Obtained Verbal Order? ☑ Yes ☐ No ☐ No Needed
Obtained Date: 10-30-2019
VO Comments

COORDINATION OF CARE
☐ MD ☐ RN ☐ LVN ☐ Aide ☐ PT ☐ OT ☐ ST ☐ MSW ☐ Pt/CG
☐ Team Leader
☐ Other _____

Therapist: _____ Date: _____

Physician: _____ Date: _____

DOB: | **VERBAL DOCTOR ORDER** | **VDO Time:** 01:00 AM

Patient Name: 101 101 | **Medicaid T #:** 12123 | **Medical Rec#:**
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☑ **DISCHARGE FROM PT REASON:**

- ☐ Reached maximal benefit from therapy
- ☐ Goals Met
- ☑ Patient request
- ☐ MD Request
- ☐ Patient Transferred
- ☐ Other asdfasdfsadfa

DISCHARGE INSTRUCTIONS:

hi these are discharge instructions

Therapist: _____ **Obtained V.O. Date:** _____

Physician: _____ **Date:** _____