

PHYSICAL ASSESSMENT							
JOINT ACTION		STRENGTH		R.O.M		FUNCTIONAL STATUS	
HIP	L	R	L	R	Previous	Current	
Abduction	3+ /5	1+ /5			Bed Mobility		
Adduction	3+ /5	1+ /5			Transfers W/C		
Rotation	3+ /5	1+ /5			Transfers Tub/Shower		
Flexion	3+ /5	1+ /5			Supine to Sit		
Extension	3+ /5	1+ /5			Sit to stand		
KNEE					Gait	Ft	
Flexion	3+ /5	1+ /5			Gait Device Type		
Extension	3+ /5	1+ /5			Weight Bearing Status	<input type="checkbox"/> R LE	<input type="checkbox"/> R LE
ANKLE						<input type="checkbox"/> L LE	<input type="checkbox"/> L LE
Dorsiflex / Plantar Flex	3+ /5	1+ /5			Other:		
Inversion / Eversion	3+ /5	1+ /5					
TRUNK							
PART/ACTION	STRENGTH		R.O.M				
SHOULDER	L	R	L	R	Stairs		
Flexion	2+ /5	2 /5			Steps / Curb		
Extension	2+ /5	2 /5			Toileting		
Abduction	2+ /5	2 /5			Wheelchair Mgmnt		
Adduction	2+ /5	2 /5			Other		
ELBOW							
Flexion	2+ /5	2 /5					
Extension	2+ /5	2 /5					
Wrist/Grip	2+ /5	2 /5					

<p><b>BALANCE</b></p> <p><input checked="" type="checkbox"/> <b>Tinetti Score</b>   <input type="checkbox"/> N/A   <input type="checkbox"/> NT</p> <p>Gait _____ Balance _____ Total _____</p> <p><input type="checkbox"/> Berg   <input type="checkbox"/> N/A   <input type="checkbox"/> _____</p> <p>Note: _____</p> <p><input type="checkbox"/> TUG   <input type="checkbox"/> N/A   <input type="checkbox"/> NT</p> <p>Note: _____</p>	<p><b>BALANCE ASSISST</b></p> <p><b>Static Sitting</b> _____</p> <p><b>Dynamic Sitting</b> _____</p> <p><b>Dynamic Standing</b> _____</p> <p><b>Note:</b> <u>unlike other monolithic fra</u> meworks, vue is designed from the</p>	<p><b>POSTURE</b></p> <p><b>Sitting Posture</b> _____</p> <p><b>Standing Posture</b> _____</p> <p><b>Transitional</b> _____</p> <p><b>Note:</b> _____</p>
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GAIT / DISTANCE / SURFACE	

SYSTEMS ASSESSMENT		PAIN ASSESSMENT		MENTAL STATUS	
BP: /	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> No Pain	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> Alert	<input type="checkbox"/> Oriented
<input type="checkbox"/> Sitting	<input type="checkbox"/> Lying <input type="checkbox"/> Standing	<input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10		<input type="checkbox"/> Disoriented	<input type="checkbox"/> Forgetful
HR:	O2 Sat %:	Location:		<input type="checkbox"/> Agitated	<input type="checkbox"/> Depressed
TEMP:	Resp:	Pain Control:			
Skin:		Time since last medication:			

<b>HOME EVALUATION</b> <input type="checkbox"/> Alone <b>Other:</b> _____ <hr/> <input type="checkbox"/> Home <input type="checkbox"/> Apt <input type="checkbox"/> Mobile Home <input type="checkbox"/> Stairs <input type="checkbox"/> Senior Complex <input type="checkbox"/> Spacious <input type="checkbox"/> Clean <input type="checkbox"/> Crowded <input type="checkbox"/> Cluttered <input type="checkbox"/> Unsound Structure <input type="checkbox"/> No Telephone available or unusable	<b>SAFETY MEASURES</b> <input type="checkbox"/> Clear Pathways <input type="checkbox"/> Fall Precaution <input type="checkbox"/> Safety at home <input type="checkbox"/> Emergency Management <input type="checkbox"/> Ortho Precautions / Restrictions <input type="checkbox"/> Steps <input type="checkbox"/> Stairs <input type="checkbox"/> 24 hr. supervision <input type="checkbox"/> Infection control measures <input type="checkbox"/> Use DME Equipment:	<b>OTHER ASSESSMENTS:</b>
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<b>DOB:</b>	<b>PHYSICAL THERAPY - Discharge</b>	<b>Time In/out:</b> 01:00-03:00 AM
<b>Patient Name:</b> 101 101	<b>Medicaid T #:</b> 12123	<b>Medical Rec#:</b>
<b>Primary Dx:</b> This is a Primary Diagnos	<b>Dx Date:</b> 07-21-2016	<b>SOC:</b> 05-01-2016
<b>Therapy Dx:</b> Therapy Diagnosis	<b>Dx Date:</b> 07-22-2016	<b>From:</b> 10-13-2019
<b>Physician:</b> ALFREDO LASSERRE, MD	<b>Clinician:</b> Ruben Neira	<input checked="" type="checkbox"/> <b>Recertif.</b> To: 12-11-2019

  
**EQUIPMENT IN THE HOME**

<input type="checkbox"/> Tub	<input type="checkbox"/> Shower Bench	<input type="checkbox"/> Handheld Shower	<input type="checkbox"/> Reacher	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Hospital Bed
<input type="checkbox"/> Bedside Comm	<input type="checkbox"/> Raised Toilet Seat	<input type="checkbox"/> Grab Bars Toilet	<input type="checkbox"/> Grab Bars Bath	<input type="checkbox"/> Grab Bars Shower	<input type="checkbox"/> Walker
<input type="checkbox"/> Grab Bars Shower	<input type="checkbox"/> Walker	<input type="checkbox"/> Rolling Walker	<input type="checkbox"/> Cane	<input type="checkbox"/> Other:	

  
**THERAPY INTERVENTION / INSTRUCTION**

<input type="checkbox"/> Evaluation	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Chest Physiotherapy	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Home Exercise Program	<input type="checkbox"/> Therapeutic Exercise
<input type="checkbox"/> Electrotherapy	<input type="checkbox"/> Muscle Reeduc	<input type="checkbox"/> Balance	<input type="checkbox"/> Gait Training	<input type="checkbox"/> Transfer Training	<input type="checkbox"/> Prosthetic Training
<input type="checkbox"/> Fabrication of Devices					
<input type="checkbox"/> Other:					

  
**FUNCTIONAL LIMITATIONS / PROBLEM AREAS**

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

  
**PLAN OF CARE**

<input type="checkbox"/> Evaluation	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Chest PT
<input type="checkbox"/> Ultrasound Treatment	<input type="checkbox"/> Gait Training	<input type="checkbox"/> Balance Training
<input type="checkbox"/> Home Exercise Program	<input type="checkbox"/> Electrotherapy	
<input type="checkbox"/> Therapeutic Exercise	<input type="checkbox"/> Muscle Re-Education	
<input type="checkbox"/> Transfer Training	<input type="checkbox"/> Prosthetic Training	
<input type="checkbox"/> Pulse Oximetry Pn	<input type="checkbox"/> Home Safety	<input type="checkbox"/> Fall Prevention
<input type="checkbox"/> Modality (specify frequency, duration, amount):		
<input type="checkbox"/> Other:		
<input checked="" type="checkbox"/> Discharge		

  
**SHORT TERM AND LONG TERM GOALS WITH TIME FRAMES**

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

  

<b>REHAB POTENTIAL</b>	<b>FREQUENCY/DURATION</b>	
<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		

<b>DOB:</b>	<b>PHYSICAL THERAPY - Discharge</b>	<b>Time In/out:</b> 01:00-03:00 AM				
<table style="width: 100%; border: none;"> <tr> <td style="width: 40%; vertical-align: top;"> <b>Patient Name:</b> 101 101  <b>Primary Dx:</b> This is a Primary Diagnos  <b>Therapy Dx:</b> Therapy Diagnosis  <b>Physician:</b> ALFREDO LASSERRE, MD </td> <td style="width: 20%; vertical-align: top;"> <b>Medicaid T #:</b> 2123  <b>Dx Date:</b> 07-21-2016  <b>Dx Date:</b> 07-22-2016  <b>Clinician:</b> Ruben Neira </td> <td style="width: 20%; vertical-align: top;"> <b>SOC:</b>  <b>From:</b> 05-01-2016  <b>To:</b> 10-13-2019 </td> <td style="width: 20%; vertical-align: top;"> <b>Medical Rec#:</b>  <b>Recertif.</b> <input checked="" type="checkbox"/>  <b>To:</b> 12-11-2019 </td> </tr> </table>			<b>Patient Name:</b> 101 101 <b>Primary Dx:</b> This is a Primary Diagnos <b>Therapy Dx:</b> Therapy Diagnosis <b>Physician:</b> ALFREDO LASSERRE, MD	<b>Medicaid T #:</b> 2123 <b>Dx Date:</b> 07-21-2016 <b>Dx Date:</b> 07-22-2016 <b>Clinician:</b> Ruben Neira	<b>SOC:</b> <b>From:</b> 05-01-2016 <b>To:</b> 10-13-2019	<b>Medical Rec#:</b> <b>Recertif.</b> <input checked="" type="checkbox"/> <b>To:</b> 12-11-2019
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<b><input checked="" type="checkbox"/> Discharge from PT Reason:</b> <input type="checkbox"/> Reached maximal benefit from therapy <input type="checkbox"/> Goals Met <input checked="" type="checkbox"/> Patient request <input type="checkbox"/> MD Request <input type="checkbox"/> Patient Transferred <input type="checkbox"/> Other asdfasdfsadfa						
<b>DISCHARGE PLANS:</b> <input type="checkbox"/> Return to an independent level of self care <input type="checkbox"/> Able to remain in residence with assist. of primary cg / support from community agencies <input type="checkbox"/> When maximum functional potential reached <input type="checkbox"/> Able to understand care related to Diagnosis <input type="checkbox"/> Other: <input type="checkbox"/> Patient / Caregiver participated in plan of care <input type="checkbox"/> Patient is OK with family involvement with care						
<b>HOME BOUND STATUS</b> <input type="checkbox"/> Considerable & taxing effort to leave home <input type="checkbox"/> Requires assistance to ambulate <input type="checkbox"/> Residual weakness <input type="checkbox"/> Dependent upon adaptive device(s) <input type="checkbox"/> Confusion, unable to go out alone <input type="checkbox"/> Other:		<b>Obtained Verbal Order?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Needed <b>Obtained Date:</b> 10-16-2019 <b>VO Comments</b>				
<b>COORDINATION OF CARE</b> <input type="checkbox"/> MD <input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> Aide <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> Pt/CG <input type="checkbox"/> Team Leader <input type="checkbox"/> Other _____						
Therapist: <u>ELECTRONICALLY SIGNED BY Ruben Neira</u>		Date: <u>10-16-2019</u>				
Physician: _____		Date: _____				

