# EVALUATION AND PLAN OF CARE

**Patient:** **MR#:** ☐ **Initial** ☐ **Recert** **SOC:**

## Diagnosis/Reason for referral to P.T.

## Prior level of function

☐ Independent ☐ Min. Assist. ☐ Mod Assist. ☐ Max Assist.
☐ W/C Bound ☐ Bed bound

**Living Situation:**

☐ Apartment ☐ House ☐ Facility ☐ B&C ☐ Mobile
☐ Alone ☐ With family/friend ☐ CG:
☐ Stairs/steps: ☐ Elevator ☐ No stairs or steps

**Vital Signs**
BP: Pulse: Resp: SpO2: Temp:

**Frequency:** **DOB:** **Gender:** ○ Male ○ Female

## Problems:

## Goals:

**Estimate Completion Date**

**Rehab Potential / Prognosis:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

## Discharge Plan

## Plan of Care/Physical Therapy Orders:

☐ PT Evaluation
☐ Therapeutic Exercise
☐ Therapeutic Activities
☐ Bed mobility / Transfer Training
☐ Nero-muscular Re-education
☐ Establish Upgrade Home Program
☐ Gait Training WB Status

☐ Safety Education
☐ Electrotherapy ☐ Ultrasound
☐ Prosthetic Training ☐ Fabrication of Orthotic Device
☐ Muscle Reeducation
☐ Management and Evaluation of Patient Care Plan
☐ Other: Pain Management
☐ Massage/Soft Tissue Mobilization to
☐ Stair Training ascending & descending

**Reason for Skilled Services:**

| | |
|---|---|
| **Bed Mobility** | |
| Roll / Scoot | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| Supine to Sit | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| Sit to Supine | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| **Transfers** | |
| Sit to stand | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| BED- Chair | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| Toilet | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| **ADL** | |
| Dressing | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| Personal Hygiene | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| Bathing / Shower | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| Feeding | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| Meal Prep | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| Home Making | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |
| Car | Dependent ☐ Max ☐ Mod ☐ Min ☐ CG ☐ SBA ☐ S ☐ I ☐ |

| **BALANCE** | **Static** | | | **Dynamic** | | | |
|---|---|---|---|---|---|---|---|
| Sitting | P- ☐ P ☐ P+ ☐ | F- ☐ F ☐ F+ ☐ | G- ☐ G ☐ G+ ☐ | P- ☐ P ☐ P+ ☐ | F- ☐ F ☐ F+ ☐ | G- ☐ G ☐ G+ ☐ | |
| Standing | P- ☐ P ☐ P+ ☐ | F- ☐ F ☐ F+ ☐ | G- ☐ G ☐ G+ ☐ | P- ☐ P ☐ P+ ☐ | F- ☐ F ☐ F+ ☐ | G- ☐ G ☐ G+ ☐ | |

**Pain** 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Edema: Site:

Sensory/Tone/Neuro: ☐ Intact ☐ Not Intact

| | **Strength** | **ROM** | **% Normal** |
|---|---|---|---|
| **B UE** | | | |
| **B LE** | | | |

Cognition/ Communication

| | | | | |
|---|---|---|---|---|
| Activity Tolerance | ☐ Poor | ☐ Fair | ☐ Good | ☐ Excellent |
| Endurance | ☐ Poor | ☐ Fair | ☐ Good | ☐ Excellent |
| Posture | ☐ Poor | ☐ Fair | ☐ Good | ☐ Excellent |
| Safety Awareness | ☐ Poor | ☐ Fair | ☐ Good | ☐ Excellent |

## Gait Description

Even surfaces: Uneven Surfaces:
Distance: Device:
Stairs: Pattern:
Precautions:

**Patient has:**

☐ SPC ☐ FWW/4WW/PUW
☐ W/C ☐ Commode
☐ QC ☐ HW
☐ Crutches ☐ Hospital bed
☐ Raised toilet seat ☐ Hoyer lift
☐ Shower chair/tub bench ☐ Other

**Equipment Recommended:**

☐ SPC ☐ FWW/4WW/PUW
☐ W/C ☐ Commode
☐ QC ☐ HW
☐ Crutches ☐ Hospital bed
☐ Raised toilet seat ☐ Hoyer lift
☐ Shower chair/tub bench ☐ Other

## Functional Limitations

☐ Amputation ☐ Paralysis/Weakness ☐ Legally Blind
☐ Bowel/Bladder ☐ Endurance ☐ Dyspnea
☐ Contractures ☐ Ambulation ☐ Impaired Vision
☐ Hearing ☐ Speech ☐ Other (Specify):
☐ Poor vision

## Knowledge/Skills Eval. ☐ Patient ☐ PCG

| | | | |
|---|---|---|---|
| Body Mech. | ☐ Poor | ☐ Fair | ☐ Good |
| Home Exercise Program | ☐ Poor | ☐ Fair | ☐ Good |
| Home Safety Management | ☐ Poor | ☐ Fair | ☐ Good |

## Activities Permitted

☐ Complete Bedrest ☐ PWB ☐ Amb w/ assist
☐ Bedrest w/ BRP ☐ Crutches ☐ Other (Specify):
☐ Up as Tolerated ☐ Walker
☐ Transfer bed/chair ☐ Cane
☐ Exerc. prescribed ☐ Wheelchair

**Mental Status** ☐ Oriented ☐ Disoriented ☐ Lethargic ☐ Forgetful ☐ Agitated ☐ Other (Specify) ☐ Comatose ☐ Depressed

**Comments**

**THERAPIST NAME:** **TITLE:**

**SIGNATURE:** _____

**PHYSICIAN NAME:**

**PHONE NUMBER:**

**SIGNATURE:** _____

**DATE:**

**TIME IN:**

**TIME OUT:**