PHYSICAL THERAPY EVALUATION AND THERAPY PLAN OF CARE

Patient Name: Milagro Mesa Date: 6/2/2025 Time In: 5 : 30 Time Out: 6 : 0

MR#: DOB: Male: ☐ Female: ☑

Physician Name: Dr. Jwan Osso Physician Phone #: (212) 263-5800

SIGNIFICANT MEDICAL HISTORY / CLINICAL FINDINGS

Primary Dx: I10 Onset Date: 5/2/2025 Rehab. Dx: R26.2

Secondary Dx: M62.81

Past Medical History: History of COPD, diabetes, hypertension, heart failure, renal disease on dialysis

Prior PT Services:

Prognosis: ☐ Poor ☐ Guarded ☐ Fair ☐ Good

Mental Status: ☑ Alert ☐ Oriented (☑ Time ☑ Place ☑ Person) ☐ Disoriented ☐ Forgetful

Other:

Vitals: Pulse: 76 /min BP: 147 / 67 RR: 18 /min Shortness of Breath when Ambulate > 20 ft: ☑ Yes ☐ No

Pulse: 94 /min BP: 161 / 74 RR: 19 /min

Pain Assessment: Pain Severity Level: 0 1 2 3 4 5 6 7 8 9 10 Location: B knees

Aggravated by: Ambulation Relieved by: rest

Type: ☑ Aching ☐ Burning ☐ Radiating ☐ Referred ☐ Spasmodic ☐ Constant ☐ Agitated ☐ Intermittent

Pain management plan established with patient: ☐ Yes ☐ No

Pulmonary Assessment: SOB noted

Musculoskeletal Assessment:		**Muscle Strength**		**Range of Motion**	
	Movements	Left	Right	Left	Right
Shoulder	Flexion/Extension			WFL	WFL
	Abduction/Adduction				
Elbow	Flexion/Extension				
Wrist	Flexion/Extension				
Fingers	Flexion/Extension				
Hip	Flexion/Extension	3+/5	3+/5	WFL	WFL
	Abduction/Adduction	3+/5	3+/5	WFL	WFL
Knee	Flexion/Extension	3+/5	3+/5	WFL	WFL
Ankle	Flexion/Extension	3+/5	3+/5	WFL	WFL
Foot	Inversion/Eversion	3+/5	3+/5	WFL	WFL
Trunk	Flexion/Extension/Rotation	3+/5	3+/5	WFL	WFL

Muscle Tone: ☑ Normal ☐ Abnormal Specify:

Balance Impairment: **Sitting** Static: Dynamic: ✔ **Standing** Static: Dynamic: ✔

Coordination: **Sensation:**

Functional Assessment:	**Current Functional Status**								**Prior Functional Status**							
	Ind	Sup	CG	Min	Mod	Max	Dep	NA	Ind	Sup	CG	Min	Mod	Max	Dep	NA
Bed mobility					✔				✔							
Supine to sit					✔				✔							
Transfer in/out of bed					✔				✔							
Bed to chair					✔				✔							
Sit to stand					✔				✔							
Toilet/commode					✔				✔							
Shower/tub transfer					✔				✔							
Orthosis/prosthesis									✔							

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Ambulation	Ind	Sup	VC	CG	Min	Mod	Max	A. Device	Distance	Prior Status
Indoors						✔		handhold	20	Indep
Outdoors										
# of stairs							✔	HR	2	indep
Gait Deviations										

Home Bound Status:

- ✔ patient needs taxing effort to leave home
- ✔ medical restrictions
- ✔ confusion unable to leave home alone
- ☐ unable to walk to elevator or street
- ☐ residual weakness
- ☐ severe SOB
- ☐ bed bound
- ☐ requires assistance for all activities

Home Assessment: Has aide 4h/d, needs more hours due to his dementi aand >5 falls in past 2 years . Patient is in severe need of more assistance. Has RW, WC, SPC

Current Functional Problem	Functional Goals and Outcome	# of Visits
Ambulation	Ambulate 200 feet with RW indep	8
Transfers	Be Indep with all transfers	8
Safety precautions	Be indep with safety precautions	8
HEP	Be indep with HEP	8

Patient/Caregiver Stated Goals: Get more aide hours due to high fall risk and safety precautions

Falls Assessment and Intervention:

Timed Up and Go Test Score: 92 sec Tinnetti Test Score: 3 /28 Functional Reach Test Score: 2 inch

Has the patient fallen in past 12 months or since the last assessment? ✔ Yes ☐ No

Does the patient need falls prevention program intervention? ✔ Yes ☐ No

Intervention and Plan of Care:

- ✔ Functional Gait Training
- ✔ Progressive Therapeutic Exercise
- ☐ Falls Prevention Management
- ☐ Orthotic/Prosthetic Training
- ✔ Transfer Training
- ✔ ROM Exercise
- ☐ Cardiopulmonary Rehabilitation
- ☐ NDT
- ✔ Progressive Balance & Coordination Training
- ✔ Establish and Upgrade Home Exercise Program
- ✔ Caregiver Education
- ✔ Postural Training

Others:

Skilled Treatment Provided this Visit: Therex for 3x10 B LES in all planes and motions , ambulation trainig, patienet education to use RW fo safety to prevent falls

Communication of Care with: ✔ MD ☐ RN ☐ Coordinator ☐ OT ☐ ST

Name:

Eval + 8 visits **visits** **Next Visit Date:** 6/6/2025

Frequency/Duration: 2x/w 4/w

Plan of Care discussed with Patient/Caregiver ✔ Yes ☐ No Patient Signature:

Therapist Name: Christopher Evangelista Therapist Signature: Date: 6/2/2025

Physician Notified: Dr. Jwan Osso 212-263-5800 Physician Signature:

to: