

Unit/Branch: _____ Patient ID#: _____

PHYSICAL THERAPY ASSESSMENT

(Without OASIS)

Adm/Eps #: _____

Patient Name: _____

Start Travel	Start Visit	End Visit	Employee #	Supervisor Approval	Service Code			Premium Code	Visit Date
							A		

BP: _____ Pulse: _____ RR: _____ Weight: _____ Temp: _____ O2 Sat: (at rest) _____ (w/exertion) _____

Diagnosis: _____ Onset: _____

Prior Level of Function: I with Ambulation Sup. or Assist to Ambulate Assistive Device Used: _____ I with ADL's Sup. or Assist with ADL's Other: _____

Pertinent Hx: _____

Cognitive Status: Patient is alert and oriented x3 Patient is confused/forgetful but able to follow directions Patient has dementia requiring constant caregiver assistancePain: None Present Location: _____ Intensity: _____ 0-10 scale

Precipitating Factors: _____ Alleviating Measures: _____

Patient is Homebound? Yes No Taxing effort to leave home due to SOB with min exertion Pain with Ambulation Unsteady gait, requires assist to ambulate Contraindicated to leave home Other: _____Social Situation: Lives alone Lives with caregiver/spouse _____ Has non-residing caregiver Other: _____

Architectural Barriers: _____

FUNCTIONAL ASSESSMENT**BED MOBILITY/TRANSFERS:**

Patient rolls in bed

 I Sup SBA CGA Min A Mod A Max A D

Patient transfers supine to sit

 I Sup SBA CGA Min A Mod A Max A D

Patient transfers sit to stand

 I Sup SBA CGA Min A Mod A Max A D

Patient transfers stand to sit

 I Sup SBA CGA Min A Mod A Max A D

Patient transfers on/off commode

 I Sup SBA CGA Min A Mod A Max A D

Patient transfers in/out of shower/tub

 I Sup SBA CGA Min A Mod A Max A D

Patient transfers into/out of car

 I Sup SBA CGA Min A Mod A Max A D

*Transfer quality/comments: _____

AMBULATION: SOB with Ambulation: Yes No Increased Pain with Ambulation: Yes NoWB Restriction: No Yes Location: _____ NWB PWB % _____ WBAT FWBPatient ambulates with: No A.D. Walker (std/rw) Cane (std/quad) Crutches Other: _____indoor/level surfaces I Sup SBA CGA Min A Mod A Max A for _____ feet N/Auneven surfaces I Sup SBA CGA Min A Mod A Max A for _____ feet N/Aoutdoors I Sup SBA CGA Min A Mod A Max A for _____ feet N/APatient ascends/descends step/stairs I Sup SBA CGA Min A Mod A Max A N/A

*Gait Quality/Deficits: _____

BALANCE: Balance is WFL or Fall Risk is: Low Risk Moderate Risk High RiskHistory of falls? Yes No Frequency of Falls: _____ Most Recent Fall: _____Reported cause of fall: Dizziness Loss of Balance Ambulating Slip/Trip/Fall Over Object UnknownTUG Test: Performed in _____ seconds (>20 Indicates Fall Risk) Not TestedTinetti Test: _____ Balance and _____ Gait Score (Balance <10 or Gait <9 indicates Fall Risk) Not Tested**STRENGTH / ROM ASSESSMENT**

Key: Strength 0/5 to 5/5 ROM in Degrees	ROM Left	Strength Left	ROM Right	Strength Right	Key: Strength 0/5 to 5/5 ROM in Degrees	ROM Left	Strength Left	ROM Right	Strength Right
Shoulder: Flexion					Hip: Flexion				
Extension					Extension				
Abduction					Abduction				
Int. Rotation					Int. Rotation				
Ext. Rotation					Ext. Rotation				
Elbow: Flexion					Knee: Flexion				
Extension					Extension				
Supination					Ankle: Dorsiflexion				
Wrist: Flexion					Plantarflexion				
Extension					Inversion				
Hand: Grasp					Eversion				

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(Without OASIS)

Adm/Eps #: _____

Patient Name: _____

OTHER LIMITATIONS: Paralysis Paresis Amputation Contractures Deformities Tremors Ataxia
 Loss of sensation Neuropathy Edema Altered Tone Altered Skin Integrity Incontinence

Describe: _____

DME: Assistive devices in use: Wheelchair Bedside Commode Raised Toilet Seat Shower Chair/Bench
 Rolling Walker Standard Walker Quad Cane Standard Cane Crutches Other: _____

Assistive devices recommended: _____**Home Safety Recommendations:** _____

INITIAL TREATMENT RENDERED (Mark all that apply): Transfer Training Gait Training Ther. Ex.

Balance Training Instruction in Pain Management Instruction in Safety/Precautions Instruction in HEP

Patient/Caregiver Training: Falls and Safety education, HEP _____

Other: _____

CLINICAL SUMMARY: _____

Communicated with Physician: Yes Physician's Name: _____ Date: _____

Case Manager Communication: Yes Comments: _____

Other: _____**PLAN OF CARE:**

- | | | |
|--|--|--|
| <input type="checkbox"/> Evaluation | <input type="checkbox"/> Patient Education | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Transfer Training | <input type="checkbox"/> Coordination/Balance Training | <input type="checkbox"/> Home Exercise Program Instruction |
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> Muscle Re-Education | <input type="checkbox"/> Pain Management: _____ |
| <input type="checkbox"/> Therapeutic Exercises | <input type="checkbox"/> Prosthetic Training | <input type="checkbox"/> Anodyne Therapy: _____ |
| | | <input type="checkbox"/> Ultrasound: _____ |

GOALS:

1. PT to evaluate to determine current physical and functional status, therapy needs and rehab potential.
2. Patient and/or caregiver will demonstrate knowledge of safety instructions and perform HEP by ____/____/____(date).
3. Patient will perform bed mobility rolling scooting supine to sit with _____ assist by ____/____/____(date).
4. Patient will perform transfers sit to stand bed to commode/chair shower/tub Other: _____ with _____ assist by ____/____/____(date).
5. Patient will ambulate level surfaces uneven surfaces up/down step/stairs/curbs with _____ device with _____ assist for _____ feet by ____/____/____(date).
6. Patient's ROM of _____ will increase from _____ to WFL to enhance patient's mobility by ____/____/____(date).
7. Patient's strength of _____ will increase from _____ to _____ to enhance patient's mobility by ____/____/____(date).
8. Patient's sitting/standing balance will improve from _____ to _____ to reduce fall risk and enhance patient's mobility by ____/____/____(date). Evidenced by improved balance scores of: Tinetti _____ balance _____ gait TUG _____ or Other: _____
9. Patient will be able to perform ADL's with _____ assist by ____/____/____(date).
10. Patient's pain level in _____ will decrease from ____/10 to ____/10 by ____/____/____(date) to enhance patient's functional mobility. PT to provide pain management techniques to _____ including: Massage Ultrasound at ____ W/cm for ____ mins Electrotherapy Anodyne Therapy Other: _____
11. Patient/caregiver will be educated on and demonstrate knowledge of _____ by ____/____/____(date).
12. Refer to: SN OT ST MSW for: _____
 Other: _____

Rehab Potential: Excellent Good Fair Poor Limited due to: _____**Discharge Plan:** Patient to be discharged from physical therapy when: Goals Met Able to go to out patient therapy

PLOF restored Maximum Potential achieved Independent with HEP Caregiver Training Complete

Patient will be discharged to care of: _____ with HEP Equipment: _____ Plan of Care and Goals were discussed with, and understood by patient/caregiver.**Level of Care**(frequency/duration): 2x/w 4w**Effective Date:** _____**Reassessment Due:** _____**Supervisory Visit Due:** _____**PT Signature:** _____**Printed Last Name:** _____**Patient Signature:** _____**Date:** _____**My signature below certifies this Plan of Care to be medically necessary.****Physician Signature:** _____ **Date:** _____**Print Name:** _____

HOME EXERCISE PROGRAM

Sitting

*2 sets x 10 reps
each side*

If exercise causes pain, dizziness or shortness of breath - **STOP**

Do Exercises 1-2 times a day.
Do Not Hold Breath!

ID#

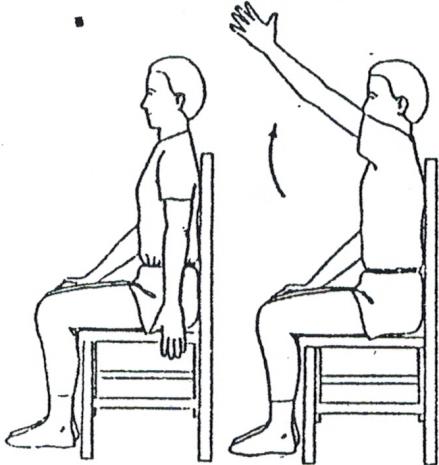
Patient Name

Chris

PT Name

CASE MANAGER:

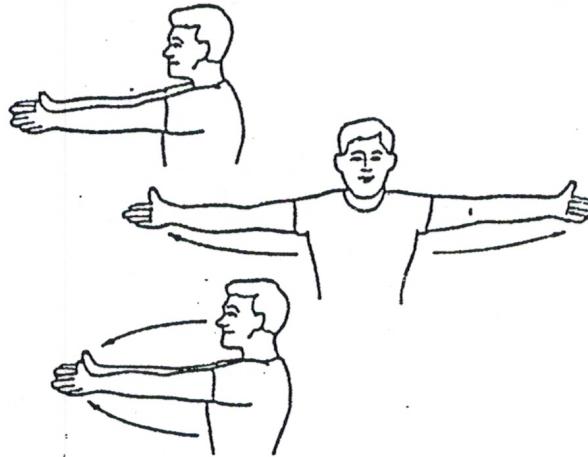
Date



Bring arm forward and overhead toward ceiling. Touch top of head. Reach up again to ceiling. Lower arm down to side.

 Alternate arms

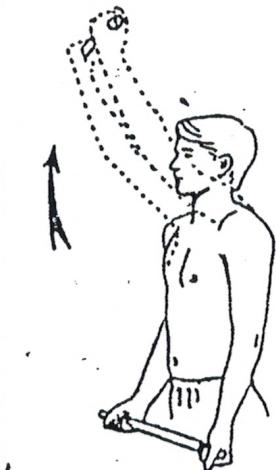
 Repetitions Sets.



Reach forward, palms facing each other. Spread arms apart, bring together.

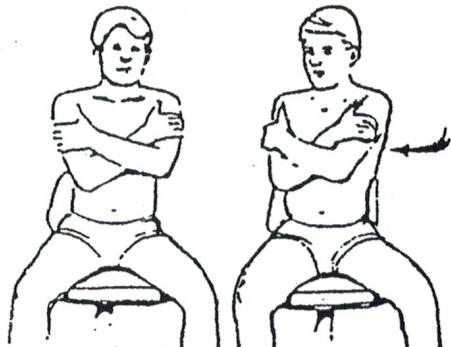
 Repetitions Sets.

 Try with palms turned up.



Holding wand with hands underneath slowly reach up overhead. Then lower

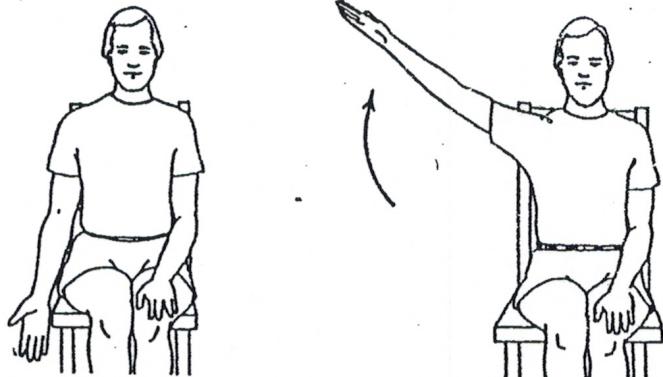
 Repetitions Sets.



Cross arms in front of body. Then twist from side to side.

 Repetitions Sets.

Try same exercise with arms at eye level.



Arms at side. Palms forward. Reach up and out to side bringing arm overhead toward ceiling. Touch top of head. Reach up again toward ceiling, then lower arm.

 Arm. Both arms Repetitions Sets.



Tap foot on floor slowly.

 Repetitions Sets.

Move foot forward for more stretch.

Circle ankles clockwise and counter-clockwise



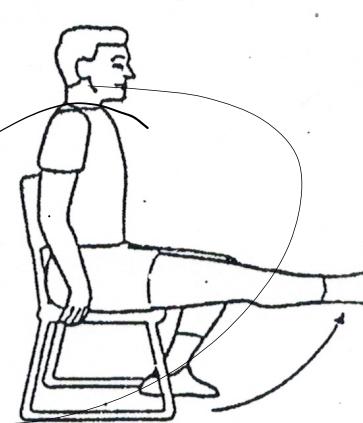
Lift heel off floor slowly, then lower. Move foot back for better stretch.

 Repetitions Sets.



Slowly lift knee up toward ceiling. Lift toes at same time. Lower to floor, heel first.

 Repetitions Sets



Slowly kick foot up toward ceiling straightening knee. Put toes toward you, then lower.

 Repetitions Sets

Date _____

PATIENT NAME: _____ ID#: _____ AGENCY: _____ MONTH: _____ YEAR: _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						

NURSE	AIDE	PHYSICAL THERAPIST	OCCUPATIONAL THERAPIST	SPEECH THERAPIST
NAME:	NAME:	NAME: <i>Chris</i>	NAME:	NAME:
PHONE:	PHONE:	PHONE: <i>723-618-6592</i>	PHONE:	PHONE:

}

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HOME EXERCISE PROGRAM

Lying Down

If exercise causes pain, dizziness or shortness of breath - **STOP**

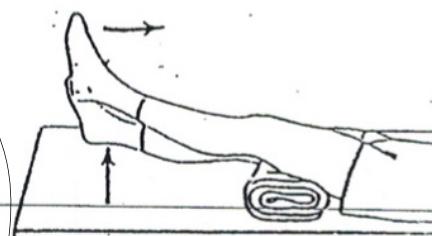
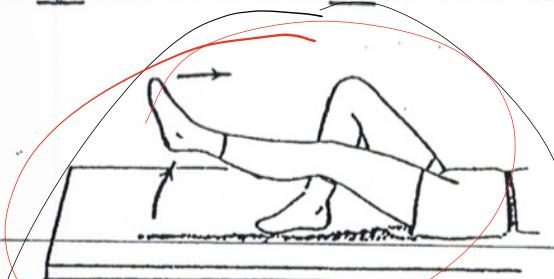
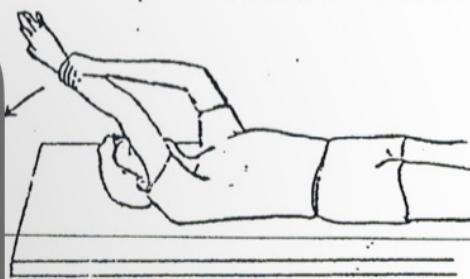
Do Exercises 2 times a day. Patient Name 10th
Do Not Hold Breath!

PT Name CASE MANAGER: Date

Quad Sets: Tighten thigh muscle to make knee as stiff and straight as possible. HOLD seconds. Relax.
 Repetitions Sets.

Glut Sets: Tighten buttock muscle and squeeze together. HOLD seconds. Relax. Repetitions Sets.

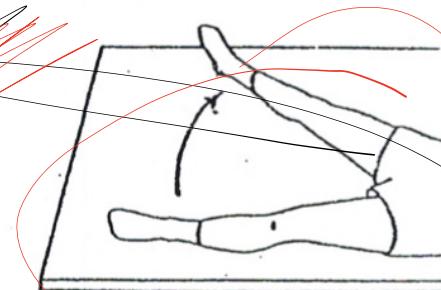
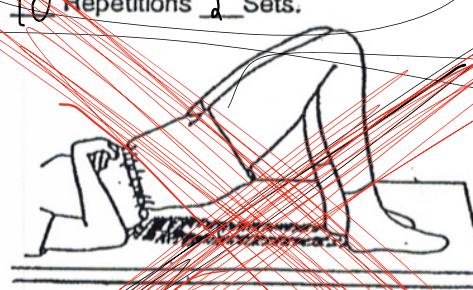
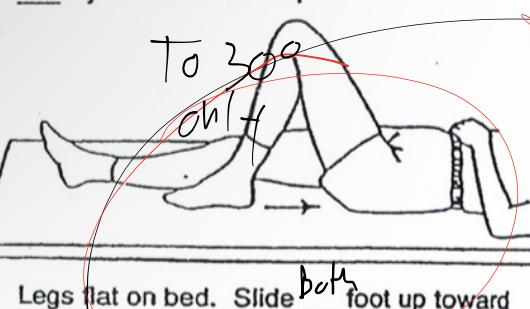
Ankle Pumps: Slowly move foot up toward head, then point foot down as much as possible. Repetitions Sets.
Then move foot in circle times one direction times other direction Repetitions Sets.



Grasp wrist with hand, then bring both arms up overhead as far as comfortably possible. HOLD seconds, then lower. Repetitions Sets.
 Try with hands clasped

Do Quad Set, then lift leg 2 inches off bed, HOLD 2 seconds, then lower down. Relax, repeat. Pull toes toward head on lifting.
10 Repetitions 2 Sets.

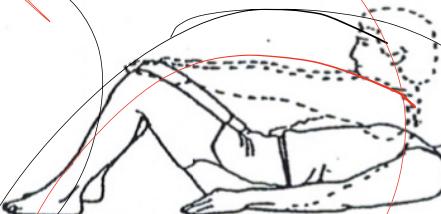
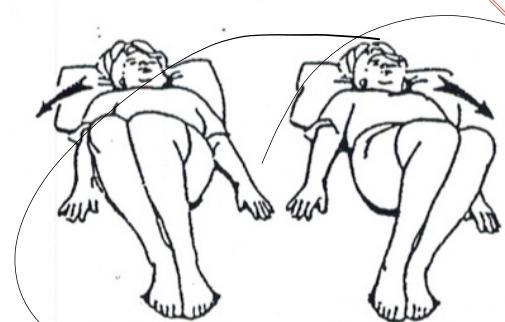
Place blanket/towel roll under knee straighten knee to lift foot off bed. Hold seconds. Pull toes toward head Repetitions Sets.



Legs flat on bed. Slide both foot up toward buttock as far as comfortably possible. HOLD 2 seconds, then slide back down straight. Repeat with other leg.
10 Repetitions 2 Sets.

Legs bent, feet flat on bed. Lift buttock up off bed as much as possible. HOLD seconds, then lower back down. Help with arms on bed if necessary.
10 Repetitions 2 Sets.

Legs flat, slide leg out to side. keep foot pointed to ceiling. HOLD seconds, pull back in. Alternate other leg 10 Repetitions 2 Sets



Pull leg up toward chest, help with hands if necessary, then straighten out knee as much as comfortably possible. HOLD seconds. Alternate with other leg.
 Repetitions Sets.

Legs bent, then bring knees over to one side as far as comfortably possible, then back to other side. 10 Repetitions 2 Sets.
Try with hands clasped and arms outstretched toward ceiling, bring arms one direction and

Legs bent, tighten stomach. Lift head shoulders off mattress reaching toward arms, then lower back down. DO NOT HOLD BREATH!
10 Repetitions 2 Sets.