COBBLE HILL LIFECARE™
YourChoice at home

THERAPY EVALUATION INITIAL VISIT
PHYSICAL THERAPY

Date of Visit: _____ Time In: _____ Time Out: _____

Patient Name: _____ ID #: _____ Age: _____

Primary Diagnosis: _____

Reason for Referral: _____

I. HISTORY / PRIOR STATUS AND FUNCTION:

Past Medical / Surgical History: _____

Precautions / Contraindications: Falls/safety

Mental Status: Alert and Oriented to ☐ **Person** ☐ **Place** ☐ **Date** ☐ **Patient is able to self-direct HHA/Caregiver**

Comments: _____

☐ **Patient requires considerable and taxing effort to leave the home due to:** ☐ **Dyspnea** ☐ **Cardiac Limitations** ☐ **Weakness**

Home Setting: ☐ **Private House** ☐ **Apartment** ☐ **Other:** _____

☐ **Outdoor Steps:** _____**step(s) Rail on:** ☐ **Right Side** ☐ **Left Side**

☐ **Indoor Steps:** _____ **step(s) Rail on:** ☐ **Right Side** ☐ **Left Side**

☐ **Elevator** **Distance to curb:** _____

Lives with: ☐ **Alone** ☐**Spouse** ☐ **Son/daughter** ☐ **Friend** ☐ **HHA/Aide** ☐ **Other:** _____

Sensation/Pain (Level): ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Location: _____

II. Findings

Vital Signs: Pre-Tx: BP_____ **HR**_____ **RR**_____ **SpO_2** _____ **Post-Tx: BP**_____ **HR**_____ **RR**_____ **SpO_2** _____

Present Functional Level:

Bed mobility	Ind	Sup	CG	Min	Mod	Max	Dep	Comments
Rolling (Left ←→Right)								
Supine ←→Sit								
Bridging								

Bed Mobility (continued):

Type of Bed: ☐ **hospital bed** ☐**standard bed** ☐ **couch** ☐ **other:** _____

Height of Bed: ☐ **standard height** ☐ **low** ☐ **high**

Adaptive Device Used: ☐ **Trapeze** ☐ **Mechanical lift** ☐ **Other:** _____

Does the member require the use of a bedrail in order to perform activity? ☐ **Yes** ☐ **No**

If yes, how much assistance is needed to safely complete activity? _____

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Patient Name: _____ ID #: _____ Date: _____

Balance: Sitting	
Static:	☐Normal ☐Good ☐Fair ☐Poor
Dynamic:	☐ Normal ☐Good ☐Fair ☐Poor
Balance: Standing	
Static:	☐Normal ☐Good ☐Fair ☐Poor
Dynamic:	☐ Normal ☐Good ☐Fair ☐Poor
Endurance:	☐Normal ☐Good ☐Fair ☐Poor

Skin Integrity: _____

AROM/PROM/TONE/STRENGTH:

_____

_____

_____

Transfers	Ind	Sup	CGa-Min	Mod	Max	Dep	N/A	Comments
Sit ←→Stand								
Stand Pivot bed ←→chair/commode								

Ass. Dev. Used for Transfers: ☐ Cane ☐ Walker ☐ Rollator ☐ Mechanical Lift ☐ Other: _____

Approximate number of times member transfers in a day: _____

Does member get out of bed at night: ☐ Yes ☐ No

If yes, how many times on average: _____

If yes, does member need assistance? _____

ADL's	Ind	Sup	CGA-Min	Mod	Max	Dep	N/A	Comments
Toilet/Tub Transfer								
Dressing								
Bathing								
Other ADL's_____								

Ambulation	Distance	Assistive Device	Ind	Sup	CGA- Min	Mod	Max	Dep	N/A	Comments
Indoors										
Outdoor										
Stair Climbing	# OF STAIRS									
Wheelchair										

Ambulation (continued):

Device Used: ☐ Cane ☐ Walker ☐ Rollator ☐ Mechanical Lift ☐ Other: _____

Weight Bearing Status: ☐ FWB ☐ WBAT ☐ PWB ☐ TTWB ☐ NWB

Gait Pattern: ☐ Normal ☐ L/R Antalgic ☐ Cautious Gait ☐ L/R Foot Drop ☐ L/R Decrease Stride
☐ Wide/Narrow Base ☐ Hemiparetic gait ☐ Shuffling Gait ☐ Festinating/Spastic ☐ Ataxic
☐ Scissoring ☐ L/R Knee Hyperextension

Other/Comments: _____

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Patient Name: _____ ID #: _____ Date: _____

Member ambulates with: ☐ AFO ☐ KAFO ☐ Shoe lift ☐ Prosthesis ☐ Other: _____

III. Therapeutic Measurable Goals (Short/Long Term):

Functional Impairments (Check all that apply) **Functional Goals: To be achieved in 8 weeks**

☐ Decreased Bed Mobility (Rolling/Sup ↔ Sit) → Improve Bed Mobility to _____

☐ Decreased Transfers (Sit ↔ Stand) → Improve transfers to _____

☐ Decreased Transfers (Bed ↔ Chair) → Improve Transfers to _____

☐ Decreased Transfers (Toilet ↔ Tub) → Improve Transfers to _____

☐ Decreased Ambulation/Gait → Increase ambulation to _____ feet with _____assist

☐ Decreased stair climbing → Increase stair climb to _____ steps with _____assist

☐ Decreased ADLs → Improve ADLs to _____

☐ Decrease Sit/Stand Balance → Improve Balance to _____

☐ Decreased Strength → Increase Strength to _____

☐ Decreased ROM → Increase ROM to _____

Other: _____ Increase/Improve to _____

IV. PLAN OF TREATMENT:

Visit Frequency/Anticipated Duration: 2 visits per week for 4 weeks for a total of 8 visits

INSTRUCTION(S)

Given to: ☒ Patient ☐ Family ☐ Caregiver ☐ Home Health Aide

Other: _____

Instructed in: ☒ Safety ☒ Activity Precautions ☐ Cardiac Precautions ☐ Energy Conservation ☒ Home Hazards

☒ Use of Assisted Devices

HEP was left at home: ☒ Yes ☐ No

If No, state reason: _____

Other: _____

Response to Instructions: ☐ Verbalized Understanding and Agreed to Comply ☐ Need Continuous Instructional Training

Other: _____

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Patient Name: _____ ID #: _____ Date: _____

Equipment Needed: _____

DME:											
Height: _____ Weight: _____lbs.											
Equipment	**Has**	**Need**	**Equipment**	**Has**	**Need**	**Equipment**	**Has**	**Need**	**Equipment**	**Has**	**Need**
Rolling Walker*	☐	☐	**Axillary Crutches***	☐	☐	**Removable W/C Arms**	☐	☐	**Grab Bar(s)**	☐	☐
Standard Walker*	☐	☐	**Forearm Crutches***	☐	☐	**Removable W/C Legs**	☐	☐	**Commode**	☐	☐
Straight cane*	☐	☐	**Hospital Bed***	☐	☐	**Shower Chair**	☐	☐	**Raised Toilet Seat**	☐	☐
Quad Cane*	☐	☐	**Wheelchair***	☐	☐	**Transfer Bench**	☐	☐	**Hemi Walker***	☐	☐
Rollator*	☐	☐	**Power Chair***	☐	☐	**Hoyer Lift***	☐	☐	**Trapeze***	☐	☐

***Require RX**

Tinetti Assessment Tool Balance and Gait Score _____ Below 19 = High Risk

Treatments: (Circle as applicable)

☐ **B1 Evaluation** ☐ **B2 Therapeutic Exercise** ☐ **B3 Transfer Training** ☐ **B4 Home Program** ☐ **B5 Gait Training** ☐ **B6 Chest Physiotherapy**

☐ **B7 Ultra Sound** ☐ **B8 Electra Therapy** ☐ **B9 Prosthetic Training** ☐ **B18 Other (Specify)** _____

☐ **L1 Develop Maintenance Program**

COORDINATION DONE WITH: ☐ Coordinator ☐ Case Manager ☐ RN ☐ MD
☐ Other: _____

Narrative: _____
_____
_____
_____

Therapist Name (Print): _____ **Date:** _____/_____/_____

x_____
Therapist Signature

Title: _____

Patient's Name (PRINT): _____

Patient's Signature: x_____

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Patient Name: _____ ID #: _____ Date: _____

TINETTI BALANCE ASSESSMENT TOOL

Tinetti ME, Williams TF, Mayewski R, Fall Risk Index for elderly patients based on number of chronic disabilities. Am J Med 1986:80:429-434

PATIENTS NAME _____ D.O.B. _____

BALANCE SECTION

Patient is seated in hard, armless chair;

		Date		
Sitting Balance	Leans or slides in chair Steady, safe	= 0 = 1		
Rises from chair	Unable to without help Able, uses arms to help Able without use of arms	= 0 = 1 = 2		
Attempts to rise	Unable to without help Able, requires > 1 attempt Able to rise, 1 attempt	= 0 = 1 = 2		
Immediate standing Balance (first 5 seconds)	Unsteady (staggers, moves feet, trunk sway) Steady but uses walker or other support Steady without walker or other support	= 0 = 1 = 2		
Standing balance	Unsteady Steady but wide stance and uses support Narrow stance without support	= 0 = 1 = 2		
Nudged	Begins to fall Staggers, grabs, catches self Steady	= 0 = 1 = 2		
Eyes closed	Unsteady Steady	= 0 = 1		
Turning 360 degrees	Discontinuous steps Continuous	= 0 = 1		
	Unsteady (grabs, staggers) Steady	= 0 = 1		
Sitting down	Unsafe (misjudged distance, falls into chair) Uses arms or not a smooth motion Safe, smooth motion	= 0 = 1 = 2		
		Balance score	/16	

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TINETTI BALANCE ASSESSMENT TOOL

GAIT SECTION

Patient stands with therapist, walks across room (+/- aids), first at usual pace, then at rapid pace.

		Date		
Indication of gait (Immediately after told to 'go'.)	Any hesitancy or multiple attempts No hesitancy	= 0 = 1		
Step length and height	Step to Step through R Step through L	= 0 = 1 = 1		
Foot clearance	Foot drop L foot clears floor R foot clears floor	= 0 = 1 = 1		
Step symmetry	Right and left step length not equal Right and left step length appear equal	= 0 = 1		
Step continuity	Stopping or discontinuity between steps Steps appear continuous	= 0 = 1		
Path	Marked deviation Mild/moderate deviation or uses w. aid Straight without w. aid	= 0 = 1 = 2		
Trunk	Marked sway or uses w. aid No sway but flex. knees or back or uses arms for stability No sway, flex., use of arms or w. aid	= 0 = 1 = 2		
Walking time	Heels apart Heels almost touching while walking	= 0 = 1		
		Gait score	/12	
		Balance score carried forward	/16	
		Total Score = Balance + Gait score	/28	

Risk Indicators:

Tinetti Tool Score	Risk of Falls
≤ 18	**High**
19 – 23	**Moderate**
≥ 24	**Low**