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:** **2 Sat:** (at rest)_____

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 assistance

Pain: ☐ 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 ☐ No

WB Restriction: ☐ No ☐ Yes Location:_____ ☐ NWB ☐ PWB %_____ ☐ WBAT ☐ FWB

Patient 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/A
uneven surfaces	☐ I	☐ Sup	☐ SBA	☐ CGA	☐ Min A	☐ Mod A	☐ Max A for_____ feet	☐ N/A
outdoors	☐ I	☐ Sup	☐ SBA	☐ CGA	☐ Min A	☐ Mod A	☐ Max A for_____ feet	☐ N/A

Patient 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 Risk

History of falls? ☐ Yes ☐ No Frequency of Falls:_____ Most Recent Fall: _____

Reported cause of fall: ☐ Dizziness ☐ Loss of Balance Ambulating ☐ Slip/Trip/Fall Over Object ☐ Unknown

TUG Test: Performed in _____ seconds (>20 Indicates Fall Risk) ☐ Not Tested

Tinetti 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				

Unit/Branch: _____ Patient ID#:_____

PHYSICAL THERAPY ASSESSMENT

(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:_____
☐ Other:_____

CLINICAL SUMMARY:_____

_____

_____

_____

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

Case Manager Communication: ☐ **Yes Comments:**_____

Other:

PLAN OF CARE:

☐ Evaluation	☐ Patient Education	☐ Other:_____
☐ Transfer Training	☐ Coordination/Balance Training	☐ Home Exercise Program Instruction
☐ Gait Training	☐ Muscle Re-Education	☐ Pain Management:_____
☐ Therapeutic Exercises	☐ Prosthetic Training	☐ Anodyne Therapy:_____
		☐ 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
☐ 3. Patient will perform bed mobility ☐ rolling ☐ scooting ☐ supine to sit with_____assist by
☐ 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 _____ 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): **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: