

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 ☐ DPatient transfers supine to sit ☐ I ☐ Sup ☐ SBA ☐ CGA ☐ Min A ☐ Mod A ☐ Max A ☐ DPatient transfers sit to stand ☐ I ☐ Sup ☐ SBA ☐ CGA ☐ Min A ☐ Mod A ☐ Max A ☐ DPatient transfers stand to sit ☐ I ☐ Sup ☐ SBA ☐ CGA ☐ Min A ☐ Mod A ☐ Max A ☐ DPatient transfers on/off commode ☐ I ☐ Sup ☐ SBA ☐ CGA ☐ Min A ☐ Mod A ☐ Max A ☐ DPatient transfers in/out of shower/tub ☐ I ☐ Sup ☐ SBA ☐ CGA ☐ Min A ☐ Mod A ☐ Max A ☐ DPatient 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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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:**

<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 _____ 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 CompletePatient 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:** _____