

PT Re-Evaluation : 09/08/2016 (300625574)

Tyndall, Vicky (207TV091515)

Date of Birth: 04/03/1956

✓ Patient identity confirmed

Time In: 07:42

Time Out: 08:33

Visit Date: 09/08/2016

Lucent Home Health, LLC

1485 Richardson Drive, Suite 135

Richardson , TX 75080

(972) 664-0945

Diagnosis / History**Medical Diagnosis:** Debility**PT Diagnosis:** Impaired Coordination, Impaired Muscular Performance, Impaired Balance**Relevant Medical History:**

HOH, L knee and L hip DJD, OA, CPAP, Supp O2 3 liters

Prior Level of Functioning:

CGA except for gait

Patient's Goals:

To increase independence and safety with functional mobility and decrease assistance required with functional mobility.

Precautions:**Homebound?** ✓ Yes ☐ No

✓ Residual Weakness

✓ Needs assistance for all activities

✓ Requires max assistance / taxing effort to leave home

Other:

✓ Unable to safely leave home unattended

✓ Severe SOB or SOB upon exertion

☐ Confusion, unsafe to go out of home alone**Social Supports / Safety Hazards****Patient Living Situation and Availability of Assistance**

Patient lives: With other person(s) in the home

Assistance is available: Occasional / short-term assistance

Current Types of Assistance Received**Safety / Sanitation Hazards**

✓ No hazards identified

☐ Steps / Stairs:☐ Narrow or obstructed walkway☐ Cluttered / soiled living area

Other:

☐ No running water, plumbing☐ Lack of fire safety devices☐ Inadequate lighting, heating and/or cooling☐ Insect / rodent infestation☐ No gas / electric appliance☐ Pets☐ Unsecured floor coverings**Evaluation of Living Situation, Supports, and Hazards****Vital Signs**

BP:	Position	Side	Heart Rate:	Respirations:	O2 Sat:	Room Air / Rate	Route
Prior 118 / 76			Prior 67	Prior	Prior		
Post 122 / 78			Post 71	Post	Post		

Comments:

Subjective Information

Patient states she is feeling fair today and very happy with skilled PT.

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Physical Assessment

	Level	Functional Impact
Orientation:		
Speech:	WFL	
Vision:	WFL	
Hearing:	WFL	
Skin:	fair turgor	
Muscle Tone:	WFL	
Coordination:	impaired	
Sensation:	impaired	
Endurance:	F-	
Posture:	F+	
Edema		
<input type="checkbox"/> Absent		
<input type="checkbox"/> Present		

Pain Assessment☐ No Pain Reported

Location	Intensity (0-10)	Location	Intensity (0-10)
Primary Site: L hip & L knee	2	Secondary Site:	
Increased by: act, position			
Relieved by: rest, time of the day, varies			
Interferes with: functional mobility			

ROM / Strength

		ROM		Strength				ROM		Strength	
Part	Action	Right	Left	Right	Left	Part	Action	Right	Left	Right	Left
Shoulder	Flexion	NT	NT	NT	NT	Hip	Flexion	50%	50%	3+/5	4-/5
	Extension	NT	NT	NT	NT		Extension	50%	50%	4/5	4-/5
	Abduction	NT	NT	NT	NT		Abduction	50%	50%	4+/5	3/5
	Adduction	NT	NT	NT	NT		Adduction	50%	50%	4-/5	4-/5
	Int Rot	NT	NT	NT	NT		Int Rot	50%	50%	4-/5	3+/5
Elbow	Ext Rot	NT	NT	NT	NT	Knee	Ext Rot	50%	50%	4-/5	3+/5
	Flexion	NT	NT	NT	NT		Flexion	50%	50%	4/5	4-/5
Forearm	Extension	NT	NT	NT	NT	Ankle	Extension	50%	50%	3+/5	4-/5
	Pronation	NT	NT	NT	NT		Plantar Flexion	50%	50%	4-/5	3/5
Finger	Supination	NT	NT	NT	NT	Neck	Dorsiflexion	50%	50%	3/5	3+/5
	Flexion	NT	NT	NT	NT		Inversion	50%	50%	4-/5	3+/5
Wrist	Extension	NT	NT	NT	NT		Eversion	50%	50%	3/5	3+/5
	Flexion	NT	NT	NT	NT		Flexion	25%	25%	4/5	4/5
Trunk	Extension	NT	NT	NT	NT		Extension	25%	25%	4/5	4/5
	Rotation	50%	50%	4-/5	3+/5		Lat Flexion	25%	25%	4/5	4/5
	Flexion	50%	50%	4/5	4-/5		Rotation	25%	25%	4/5	4/5

Description of Functional Impact:

Functional Assessment

Independence Scale Key	Dep	Max Assist	Mod Assist	Min Assist	CGA	SBA	Supervision	Ind with Equip	Indep
Bed Mobility									
Rolling									
	Assist Level					Assist Level	Distance / Amount		Assistive Device
	SBA	✓ L ✓ R							
		Assistive Device							
Supine - Sit	Mod x 1			Level	unable		X		
Sit - Supine	Mod x 1			Unlevel			X		
Factors Contributing to Functional Impairment:				Steps /			X		
				Stairs					
				Factors Contributing to Functional Impairment:					

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Transfer

	Assist Level	Assistive Device
Sit - Stand	unable	
Stand - Sit	unable	
Bed - Wheelchair	Total	
Wheelchair - Bed	Total	
Toilet or BSC		
Tub or Shower		
Car / Van		

Factors Contributing to Functional Impairment:

Wheelchair Mobility

	Assist Level	Assist Level	Assist Level
	Level Max	Unlevel	Maneuver
Factors Contributing to Functional Impairment:			

Weight Bearing Status**Balance**

☐ Able to assume midline orientation
☐ Able to maintain midline orientation
 Sitting:
 Standing:

Fall Risk and Other Testing

	Test Used	Other	Test Results
Cognition			
Sensation			
Endurance			
Balance			
Gait			
Bal			
Confidence			
DME			

Available

☐ Wheelchair ☐ Walker ☐ Hospital Bed ☐ Bedside Commode ☐ Raised Toilet Seat ☐ Tub / Shower Bench
 Other:

Needs**Clinical Statement of Assessment Findings and Recommendations**

Patient re-assessed 9/8/16. Patient is progressing well with therapy treatments thus far and demonstrates functional gains towards goals. Patient continues to progress towards Goal #1-8. Continued skilled Physical Therapy for Mrs. Tyndall is required to appropriately address continued deficits and facilitate return to prior level of function and effective, efficient, and safe functional mobility throughout the patient's residence and local community. Patient re-educated and displayed understanding (Continued)

Treatment Goals

	Time Frame
1: Improve BLE strength by 1 MMT grade throughout major muscles.	4 weeks
2: Improve trunk strength by 1 grade MMT all directions.	4 weeks
3: Endurance with functional mobility improved to grade: Fair.	3 weeks
4: Improve posture with functional mobility to grade: Fair.	4 weeks
5: Patient to demonstrate pressure relief with positional changes w/ CGA.	5 weeks
6: Patient to sit EOB with Max A x 1 for 1 minute w/ posture grade: Fair.	7 weeks
7: Patient to demonstrate bed mobility: rolling L<>R and supine<>sit CGA.	7 weeks
8: Patient to demonstrate bed<>w/c transfer CGA with effective & safe strategy.	7 weeks
9:	
10:	

☐ **No Change to Plan of Care:** physician signature is not required if no change to Plan of Care for therapy reassessment visit

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Treatment Plan

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Thera Ex | <input checked="" type="checkbox"/> Balance Training | <input checked="" type="checkbox"/> Home Safety Training |
| <input type="checkbox"/> Hip Precaution Training | <input checked="" type="checkbox"/> Muscle Re-education | <input type="checkbox"/> Assistive Device Training: |
| <input type="checkbox"/> Establish or Upgrade HEP | <input checked="" type="checkbox"/> Bed Mobility Training | <input checked="" type="checkbox"/> Modalities for Pain Control: |
| <input type="checkbox"/> Knee Precaution Training | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> CPM: <small>as appropriate</small> |
| <input checked="" type="checkbox"/> Transfer Training | <input type="checkbox"/> Prosthetic Training | |
| <input type="checkbox"/> Pulmonary Physical Therapy | <input type="checkbox"/> Electrotherapy | |
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> Stairs / Steps Training | |
| <input checked="" type="checkbox"/> Range of Motion | <input type="checkbox"/> O2 Sat Monitoring PRN | |

Other:

Comments:

Care Coordination

Conference with:

☐ PT ☒ PTA ☐ OT ☐ COTA ☐ ST ☐ SN ☐ Aide ☐ Supervisor Other:

Name(s): David Carrera

Regarding: progress

☐ Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction

Other Discipline Recommendations: ☐ OT ☐ ST ☐ MSW ☐ Aide Other:

Reason:

Statement of Rehab Potential

This patient has the potential to benefit from interventions provided by physical therapy

☒ Yes ☐ No

Treatment / Skilled Intervention This Visit

☒ Completion of the evaluation and development of the plan of care

☐ Other

Frequency and Duration

	Start Date	End Date	Effective Date	Frequency
Current Episode:	07/11/2016	09/08/2016		
Next Episode:	09/09/2016			PT/PTA FREQ to cont in the new cert effective 9/12: 1w1,2w6

Discharge Plan

☒ To self care when goals met ☒ To self care when max potential achieved ☐ To outpatient therapy with MD approval

☐ Other:

Therapist Signature (Lewis ,Michael Bram) & Date of Verbal Order for Start of PT Treatment
Digitally Signed by: Michael Bram Lewis , DPT[Home Care Rehab Svc.]

Date
09/08/2016

Physician Name
SUMANA KETHA

Physician Phone: (972) 675-7313
Physician FAX: (972) 675-7310

Physician Signature
Digitally Signed by: SUMANA KETHA MD

Date
09/20/2016

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Clinical Statement of Assessment Findings and Recommendations

of expectations, risks, benefits, and precautions associated with receiving home health skilled Physical Therapy.

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