Clear Form

RecoverHealth
We bring health care home

PHYSICAL THERAPY EVALUATION

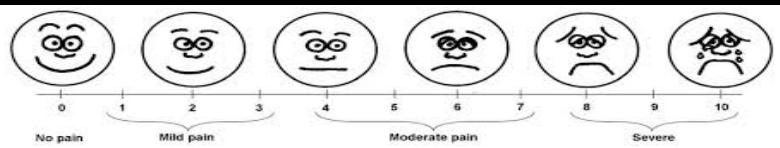
CLIENT NAME	**SERVICE DATE** **DOB**	**BRANCH**	**TIME IN: ____** **TIME OUT: ____**

HOMEBOUND REASON (*check one*): ☐ Dependent on adaptive device(s) ☐ Requires assistance to ambulate
☐ Severe pain ☐ Medical Restrictions ☐ Severe SOB with _____
☐ Other (specify)_____
(MANDATORY) **UNABLE TO LEAVE HOME SAFELY DUE TO:** _____
_____

PERTINENT BACKGROUND INFORMATION

PRIMARY MEDICAL DIAGNOSIS: _____**Onset:** _____
PERTINENT MEDICAL HISTORY:
_____
GENERAL PRIOR LEVEL OF FUNCTION:
_____
LIVING SITUATION / SUPPORT SYSTEM: ☐Capable, willing caregiver available ☐Limited caregiver (ability/willingness)
☐ No caregiver available _____
HOME / SAFETY BARRIERS: ☐ Uneven floors/doorsills ☐ Poor lighting ☐ Indoor pets ☐ Improper/unsafe footwear
☐ Structural barriers (lack of handrails, stairs) ☐ Scatter rugs / loose carpet ☐ Cords through walkways
☐ Tubing (oxygen, catheter) ☐ Tub/Shower access ☐ Other:_____

MEDICATIONS REVIEWED? ☐ Yes ☐ No **COMPLIANT WITH MED REGIMEN?** ☐ Yes ☐ No	**ANY NEW/CHANGED MEDICATIONS?** ☐ Yes ☐ No If Yes, document change: _____ If Yes, Medication profile updated? ☐ Yes ☐ No

VITAL SIGNS	**PAIN**
BP: ____/____ ☐ ***Sitting*** ☐ ***Standing*** ☐ ***Supine***	 **_____/10**
BP: ____/____ ☐ ***Sitting*** ☐ ***Standing*** ☐ ***Supine***	
Pulse: ____ ☐**Regular** ☐**Irregular**	**Pain Location:** _____
	Pain Description: _____
Oxygen Saturation: ____%	**Aggravating Factors:** _____
	Alleviating Factors: _____

SENSORY / FACTORS IMPACTING FUNCTION

☐**Alert** ☐**Oriented x_____** ☐ **Cooperative** ☐ **Confused** ☐ **Memory deficits** ☐ **Impaired judgement**

SKIN/INTEGUMENTARY CONCERNS	
EDEMA: (location, severity)	
VISION OR HEARING	
SAFETY AWARENESS	

MUSCLE STRENGTH/FUNCTIONAL ROM

STRENGTH (joint, side (R/L) or functional test)	
ROM (active, passive, joint, side (R/L))	
AMBULATION (level of assist, device, distance)	

Comments:

CLIENT NAME	SERVICE DATE	BRANCH

Code the patient's usual performance at evaluation for each activity using the 6-point scale. If activity was not attempted at evaluation, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06.**Independent** – Patient completes the activity by him/herself with no assistance from a helper
05.**Set-up or clean-up assistance** – helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04.**Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03.**Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs and provides, but provides less than half the effort.
02.**Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01.**Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2or more helpers is required for the patient to complete the activity.
If activity was not attempted, code reason
07.**Patient Refused**
09.**Not applicable** – not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10.**Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88.**Not attempted due to medical conditions or safety concerns**

Evaluation Performance	Discharge Goal	
		Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
		Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
		Toilet transfer: The ability to get on and off a toilet or commode.
		Car Transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.
		Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.
		Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
		Walk 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
		1 step (curb): The ability to go up and down a curb and/or up and down one step.
		4 steps: The ability to go up and down four steps with or without a rail.
		12 steps: The ability to go up and down 12 steps with or without a rail.
		Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		Does patient use wheelchair and/or scooter? (Yes/No) *If 'NO' then below sections may remain empty*
		Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		Indicate the type of wheelchair or scooter used. 1 = Manual, 2 = Motorized
		Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		Indicate the type of wheelchair or scooter used. 1 = Manual, 2 = Motorized

Comments:

CLIENT NAME					SERVICE DATE	BRANCH
Functional Areas	Prior Level of Function (PLOF)	Current Level of Function (CLOF)	Goal	CLOF (minus) Goal	Scoring Key: **The level of ability refers to the level of assistance (if any) that the patient requires to *SAFELY* complete a specified task.**	
Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.				*Multiply by 3*	0 = Able to independently transfer. 1 = Able to transfer with minimal human assistance or with use of an assistive device. 2 = Able to bear weight and pivot during the transfer process but unable to transfer self. 3 = Unable to transfer self and is unable to bear weight or pivot when transferred by another person. 4 = Bedfast, unable to transfer but is able to turn and position self in bed. 5 = Bedfast, unable to transfer and is unable to turn and position self.	
Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.				*Multiply by 3*	0 = Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device). 1 = With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2 = Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3 = Able to walk only with the supervision or assistance of another person at all times. 4 = Chairfast, unable to ambulate but is able to wheel self independently. 5 = Chairfast, unable to ambulate and is unable to wheel self. 6 = Bedfast, unable to ambulate or be up in a chair.	
When is the patient dyspneic or noticeably **Short of Breath**?					0 = Patient is not short of breath 1 = When walking more than 20 feet, climbing stairs 2 = With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 = With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 = At rest (during day or night)	
Frequency of Pain Interfering with patient's activity or movement:					0 = Patient has no pain 1 = Patient has pain that does not interfere with activity or movement 2 = Less often than daily 3 = Daily, but not constantly 4 = All of the time	
Objective Measure					Tinetti: **(2)** ≤18 (high fall risk) **(1)** 19-23 (moderate fall risk) **(0)** ≥24 (low fall risk) Berg: **(2)** 0-20 (wheelchair bound) **(1)** 21-40 (walking with assist) **(0)** 41-56 (independent) **Other:**	
Did patient receive post-acute (skilled nursing facility, inpatient rehabilitation facility, long term care hospital, or inpatient psychiatric facility) **care in the 14 days prior to the HH admission**					Yes = 2 No = 0	
Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)** *INSTRUCTION: 1 POINT FOR EACH RISK IDENTIFIED*					☐ - History of falls (2 or more falls – or any fall with an injury – in the past 12 months) ☐ - Multiple hospitalizations (2 or more) in the past 6 months ☐ - Diagnosis of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, or Diabetes Mellitus	
					←Sum of column (CDCP Score)	

Objective Measure Documentation (Berg, Tinetti, TUG, etc..)

Comments:

CLIENT NAME	EVALUATION DATE	BRANCH	PHYSICIAN NAME

☐ INITIAL EVALUATION ☐ RE-EVALUATION CLIENT SIGNATURE:

Primary Diagnosis & Reason for PT: _____

_____ Onset: _____

Frequency & Duration of PT POC: _____ effective week of: _____

PHYSICAL THERAPY INTERVENTIONS

	Evaluation		Manual therapy techniques		Establish home exercise program ☐ Copy given to client ☐ Copy attached to chart
	Therapeutic exercise to develop strength, flexibility, range-of-motion		Gait training (including stair climbing)		
	Neuromuscular reeducation of movement, balance, coordination		Sensory reintegration to enhance responses to environmental demands		WC Management (assessment/fitting when not otherwise reported, training)
	Therapeutic activities to improve functional performance		Self-care/home management training & compensatory training		Orthotic(s) management & training of UE, LE &/or trunk
	Pain management strategies		Other: _____		Checkout for Orthotic use

ANALYSIS / CARE PLANNING / TREATMENT

☐ PT Evaluation only. No further indications for service

☐ Client appropriate for additional services; Need verbal orders

Instruction provided this date: ☐ Safety training
☐ Exercise ☐ Other: _____
☐ Equipment Needs: _____
_____

☐ Refer to _____ for evaluation.

DISCHARGE PLANNING DISCUSSED WITH: ☐ Client
☐ Family ☐ Physician ☐ Care Manager ☐ Other (specify) _____

CARE COORDINATION: ☐ Physician ☐ SN ☐ PTA ☐ OT ☐ ST ☐ HHAide ☐ ALF Staff ☐ Other: _____

APPROXIMATE NEXT VISIT DATE: ____/____/____

GOALS FOR PHYSICAL THERAPY

CLIENT/CAREGIVER'S DESIRED OUTCOMES FROM P.T.:

All goals to be written in SMART format: Specific, Measurable, Attainable/Achievable, Relevant, Time-Bound.

TRANSFERS	**Short term** ☐ **Long term** ☐	
AMBULATION	**Short term** ☐ **Long term** ☐	
DYSPNEA	**Short term** ☐ **Long term** ☐	**Patient will demonstrate increased endurance/tolerance with ability to _____ _____ with no signs or symptoms of breathlessness.**
PAIN	**Short term** ☐ **Long term** ☐	**Patient will demonstrate effective pain control through _____, reducing pain from __/10 to __/10, allowing for _____**
Obj. Measure/Fall Prevention	**Short term** ☐ **Long term** ☐	
HEP COMPLIANCE	**Short term** ☐ **Long term** ☐	**Patient will demonstrate ability to perform Home Exercise Program independently, or with assist of caregiver, resulting in improvements in _____**
HOSPITALIZATION PREVENTION	**Short term** ☐ **Long term** ☐	**Patient will understand how and when to contact Recover Health clinicians, and will demonstrate ability to maintain medical condition in home without unplanned hospitalization or ER visit.**
OTHER:	**Short term** ☐ **Long term** ☐	
OTHER:	**Short term** ☐ **Long term** ☐	

Short term goals to be achieved in _____ weeks

Long term goals to be achieved in _____weeks

REHAB POTENTIAL: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Due to: _____

DISCHARGE PLAN: Discontinue Physical Therapy when client meets goals or reaches maximum rehab potential.

Client / Caregiver aware of POC & agreeable to POC: ☐ **Yes** ☐ **No (explain)**_____

Plan developed by: _____ Date: _____Time: _____
Professional signature and title

PHYSICAL THERAPY CARE PLAN & PHYSICIAN'S ORDERS

Verbal Orders received from _____ by: _____Date: _____ Time: _____
MD Phone Number: _____ ***Professional signature & title*** ☐ Orders read back & verified
Physician Signature: _____ Date: _____ Time: _____
Please sign & return promptly