Clear Form

RecoverHealth
We bring health care home

PHYSICAL THERAPY REASSESSMENT

CLIENT NAME	REASSESSMENT DATE	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:** _____
_____

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

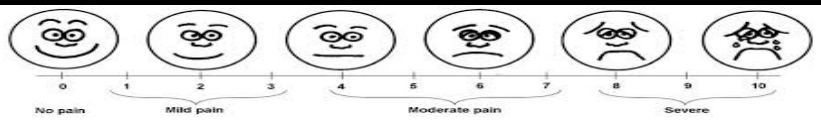
BP: ____/____
☐ *Sitting* ☐ *Standing* ☐ *Supine*

BP: ____/____
☐ *Sitting* ☐ *Standing* ☐ *Supine*

Pulse: ____
☐ Regular ☐ Irregular

Oxygen Saturation: ____%

PAIN



_____/10

Pain Location: _____
Pain Description: _____
Aggravating Factors: _____
Alleviating Factors: _____

Client is still receving services of: ☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ Other: _____

TRANSFERS	**Goal Met?** ☐ Yes ☐ No	
Comments: _____		
AMBULATION	**Goal Met?** ☐ Yes ☐ No	
Comments: _____		
DYSPNEA	**Goal Met?** ☐ Yes ☐ No	**Patient will demonstrate increased endurance/tolerance with ability to _____ _____ with no signs or symptoms of breathlessness.**
Comments: _____		
PAIN	**Goal Met?** ☐ Yes ☐ No	**Patient will demonstrate effective pain control through _____, reducing pain from __/10 to __/10, allowing for _____**
Comments: _____		
OBJECTIVE MEASURE	**Goal Met?** ☐ Yes ☐ No	
Comments: _____		
HEP COMPLIANCE	**Goal Met?** ☐ Yes ☐ No	**Patient will demonstrate ability to perform Home Exercise Program independently, or with assist of caregiver, resulting in improvements in _____**
Comments: _____		
HOSPITALIZATION PREVENTION	**Goal Met?** ☐ Yes ☐ No	**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.**
Comments: _____		
OTHER / NEW GOAL:	**Goal Met?** ☐ Yes ☐ No	
Comments: _____		
OTHER / NEW GOAL:	**Goal Met?** ☐ Yes ☐ No	
Comments: _____		

Provied justification as to <u>why</u> the client will <u>continue to require skilled therapy services</u>. Use statements that will objectively assess client's response to therapy. Provide information to explain what treatment is no longer needed & what adjustments will be made in treatment next period. Relate the results to functional outcomes and remaining impairments. Document therapy skill performed during today's visit

******PHYSICAL THERAPY* should continue due to:** ☐ Pt potential to improve materially in a reasonable & generally predictable period of time based on the POC ☐ A pT's skills/knowledge are needed to design/establish a safe maint. Program ☐ A PT's skills/knowledge are needed to perform a safe maint. program

Supervisory Visit for: ☐ **PTA** ☐ **HHA**
Is He/She **Present?** ☐ Yes ☐ No

Following Care Plan? ☐ Yes ☐ No
Client/Caregiver Satisfied with Service? ☐ Yes ☐ No

☐ **Plan Of Care Reviewed/Revised with Client/Caregiver Involvement**

CLIENT SIGNATURE:

Therapist Signature & Professional Designation: _____ **Date:** _____ **Time:** _____

CLIENT NAME				SERVICE DATE	BRANCH
Functional Areas	Evaluation Level of function	Current Level of Function (CLOF)	Goal Level of function	Scoring Key	
Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.				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.				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:**	

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

Comments:

ANALYSIS / CARE PLANNING / TREATMENT

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

☐ Client appropriate for additional services; Need verbal orders

☐ 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.: _____
_____