Clear Form

RecoverHealth
We bring health care home

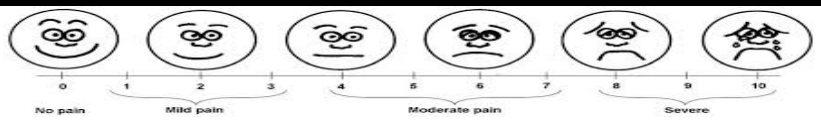
PHYSICAL THERAPY TREATMENT

CLIENT NAME	SERVICE DATE	EMPLOYEE NAME	BRANCH:

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

TREATMENT THIS DATE

Subjective:

EXERCISE (name, frequency, assistance, instructions)	
TRANSFERS (type, frequency, assistance, instructions)	
AMBULATION (distance, AD, instructions, assistance)	
OTHER (Treatments, standardized tests, balance, education)	

Progress toward functional areas (transfers, ambulation, dyspnea, pain):

Response to treatment:

Plan for next visit:

Home Exercise Program (update each visit):

Discharge Planning:

CARE COORDINATION: ☐Physician ☐SN ☐PT ☐PTA ☐OT ☐OTA ☐ST ☐Aide ☐ALF Staff ☐Other: _____
Regarding: _____

Supervisory Visit for: ☐ PTA ☐ HHA	Is he/she present? ☐ Yes ☐ No	Following Care Plan? ☐ Yes ☐ No
Plan of Care Reviewed/Revised with Client/Caregiver Involvement ☐		Client/Caregiver Satisfied with Service ☐ Yes ☐ No

Employee Signature: _____ **Date:** _____ **Time:** _____