REASON HOMEBOUND

AMBULATE: ☐ 1-10ft ☐ 10-25ft ☐ 25-50ft
WITH: ☐ No devices ☐ Walker ☐ cane ☐ crutches
Assist: ☐ Standby ☐ Min. ☐ Mod. ☐ Max.
Taxing Effort: ☐ SOB ☐ Pain ☐ Lack of Endurance
☐ Poor Balance ☐ Unsteady Gait
☐ Nausea ☐ Dizziness
☐ Other: ______________________________

☐ Patient is Essentially Bed bound.
☐ Other: ____

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PHYSICAL THERAPY VISIT NOTES

ASSESSMENT

7-Complete Independence 6-Moderate Independence 5-Standby Assist. 4-Min. Assist. 3-Mod. Assist. 2-Max. Assist. 1-Total Assist.

Gait____________ ☐Bed Mobility____________ ☐W/C Mobility______________ ☐Transfers______________ ☐Other__________

☐Limited ROM ☐Weakness ☐Balance ☐Endurance ☐Coordination ☐Edema ☐HEP Deficit ☐Pain ☐Safety ☐ADL's

Equipment Needs:____

Comments: ____

SKILLED INTERVENTIONS

Patient identification done using direct facial recognition of patient and PCG, and patient's address. Opened a unit of Universal Precaution Kit. Established clean work area Cleansed stethoscope & Thermometer with alcohol wipes. Used thermometer probe. Hand washing done before and after patient care. Skilled assessment of system done.

INTERVENTIONS

☐ Evaluation______________________	☐ Level ___________ ☐ Stair ___________	☐ Other
☐ Therapeutic Exercise______________	☐ Curb ____________ ☐ Ramp __________	☐ Safety Training
☐ Passive ☐ Active Assisted	☐ Assistance-Devics __________________	☐ Equipment training
☐ Active ☐ Resistive ☐ Balance	☐ Stand by Assistance_________________	☐ ADL Training
☐ Coordination ☐ Instruct In HEP	☐ Max ☐ Mod ☐ Min	☐ Chest/Breathing Therapy
☐ Transfer Training ________________	☐ Contact Guard	☐ Ortho Precautions
☐ Bed/Chair/Toilet ☐ Shower/tub	☐ Verbal Cueing	☐ Edema Reduction
☐ Bed Mobility ☐ W/C ☐ Auto	☐ Independent	☐ Body Mechanics
☐ Floor	☐ Pulmonary P.T. __________________	☐ Energy Conservation/Endurance
☐ Home Program ___________________	☐ Ultrasound________________________	☐ Tone Reduction
☐ Gait Training ____________________	☐ Electrotherapy ____________________	☐ Prosthetic training
☐ WB Status _____________________	☐ Prosthetic Training__________________	
	☐ Fabrication Temporary Devices	
	☐ Muscle Re-Education	

Patient/Caregiver Response:

Written/Printed Instruction given:

Progress Towards Goals:

Plan for Next Visit: ☐ Hold ☐ Revisit for:

☐ Change Frequency/Service

Discharge Plan: ☐ Projected Date: ☐ Plan Discussed:

Communications with: ☐ MD ☐ RN ☐ PT ☐ OT ☐ SLP ☐ MSW ☐ Aide ☐ Other:

Name: ____ RE: ____

PTA/HHA Present . YES ☐ NO Name of PTA/HHA _______________ PTA/HHA Observed Performing: ____________________

PT/CG Reports: ____PT/CG Satisfied with care ☐ YES ☐ NO

Comments:

Signature/Title:	Time In	Time Out	Travel Time	Chart Time	Total Time	Bill --- Yes --- No

Patient Name: ____________________________________ Date_________________________