HOME REHABILITATION HEALTH CARE AGENCY

PHYSICAL THERAPY EVALUATION

And PLAN OF CARE

Primary Medical History	Date of Onset	SOC date	Date of Birth

Significant Medical History	Prior Level of Function:

PROBLEMS
- ❑ IMPAIRED BED MOBILITY_____
- ❑ IMPAIRED TRANSFER _____
- ❑ IMPAIRED AMBULATION_____
- ❑ DECREASED ROM _____
- ❑ IMPAIRED MSCL STRENGTH _____
- ❑ IMPAIRED BALANCE _____
- ❑ IMPAIRED COORDINATION _____
- ❑ PAIN _____ON SCALE OF 0-10 _____
- ❑ NO HOME EXERCISE PROGRAM _____
- ❑_____
- ❑_____

GOALS/TIME FRAME
- ❑ IMPROVE BED MOBILITY TO_____
- ❑ IMPROVE TRANSFER TO_____
- ❑ IMPROVE AMBULATION TO_____
- ❑ INCREASE ROM TO_____
- ❑ INCREASE MSCL STRENGTH TO_____
- ❑ INCREASE BALANCE TO _____
- ❑ IMPROVE COORDINATION TO _____
- ❑ DECREASE PAIN TO_____ON SCALE OF 0-10 _____
- ❑ ESTABLISH HOME PROGRAM _____
- ❑_____
- ❑_____

REHAB POTENTIAL/PROGNOSIS
❑ EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR

DISCHARGE PLAN

PLAN OF CARE/PHYSICAL THERAPY ORDERS
- ❑ B1 Evaluation
- ❑ B2 Therapeutic Exercise: _____
- ❑ B3 Transfer training
- ❑ B4 Home exercise Program ❑ Establish ❑ Updated
- ❑ B5 Gait training WB Status _____ Device _____
- ❑ B6 Pulmonary Physical Therapy
- ❑ B7 Ultrasound
- ❑ B8 Electrotherapy
- ❑ B9 Prosthetic training ❑ Preprosthetic
- ❑ B10 Fabrication of Orthotic Device
- ❑ B11 Muscle Reduction
- ❑ B12 Management and Evaluation of Patient care Plan
- ❑ B13 Other _____

FREQUENCY AND DURATION _____

EVALUATION: FUNCTIONAL STATUS

FUNCTIONAL ACTIVITIES	INDEP	SUPERV.	ASSIST	UNABLE
BED MOBILITY				
SUPINE - SIT				
SCOOTING				
ROLLING				
TRANSFERS				
SIT – STAND				
BED – CHAIR/ or WC				
SHOWER				
TOILET				
CAR				
FLOOR-STAND				
W/C MOBILITY				
PROPELS/STEER				
GAIT				
EVEN				
UNEVEN				
STAIRS				

Analysis

EVALUATION: GENERAL

	Strength	ROM
Trunk		
Cervical		
Extremities: Upper		
Lower		

NEURO STATUS					
COGNITION/COMMUNICATION					
ENDURANCE BP HR Resp					
POSTURE					
PAIN/EDEMA					
BALANCE P= Poor, F= Fair G=Good, N=Normal	P	F	G	N	
SITTING STATIC					
DYNAMIC					
STANDING STATIC					
DYNAMIC					
HOMEBOUND STATUS					
Unusual Rehab Environment/Comments:					
Equipment in Home: / Equipment Needs:					
Safety assessed: ❑ environment ❑ Equipment ❑ Fall Precautions ❑ Emergency Preparedness					
Refer to: ❑ OT ❑ ST ❑ HHA ❑ SN ❑ MSW					

Comments

POC Established with
❑ Patient ❑ Family ❑ Other

Physician Name & Phone

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.

PT SIGNATURE: _____ DATE_____

PATIENT NAME_____ PATIENT SIGNATURE_____