OT

BRIGHTSTAR HOME HEALTH

THERAPY VISIT NOTE

VISIT: ☐ Scheduled ☐ Supervisory

Heart Rate: ☐ Rest _____ min Exercise: _____ min Recovery Rate: _____min Coping Ability:_____ B/P: R_____
Respiration: ☐ Rest _____ min Exercise: _____ min Recovery Rate: _____ min Good/Fai8r/Poor L_____

PAIN ASSESMENT: ☐ Denies pain ☐ Intensity (1-10) _____ Site:_____ No Pain Mod Pain Worst Pain
Description: ☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Intractable | | | | | | | | | | |
Relieved by:_____ Effective: ☐ YES ☐ NO 0 1 2 3 4 5 6 7 8 9 10

SKILLED INTERVENTIONS (Mark all Interventions Provided)

☐ EVALUATION
☐ THERAPEUTIC EXERCISES
☐ Passive ☐ Active ☐ Assistive ☐ Resistive ☐ Other
☐ TRANSFER TRAIN
☐ Bed/Chair/Toilet ☐ Shower/Tub ☐ Bed mobility ☐ Auto ☐ Floor
☐ EXERCISE PROGRAM
☐ Establish HEP ☐ Upgrade HEP (explain)_____
☐ GAIT TRAINING MOBILITY:
☐ WB status _____
☐ Ambulation Device_____
☐ Other:_____
☐ PULMONARY THERAPY:
☐ Breathing Exercises ☐ Postural Drainage ☐ Chest percussion
☐ Other:_____

☐ ULTRASOUND
☐ _____ w/cm x _____ min to _____
☐ ELECTROTHERAPY: ☐ Tens area:_____
☐ PROSTHETIC TRAINING
☐ Stump Care ☐ Prosthetic Fit
☐ MUSCLE RE-EDUCATION:
☐ Muscle re-education for:_____
☐ OTHER:
☐ Safety Training ☐ Equipment Training
☐ Pain Management (specify:_____
☐ Whirlpool ☐ Energy Conservation
☐ Other Modalities: _____
☐ Other modalities:_____
☐ Other Modalities:_____

PATIENT REMAINS HOMEBOUND (State Reason)_____

CLINICAL SUMMARY (Assessment, Skilled Interventions and Education)

_____
_____
_____
_____
_____
_____
_____

PATIENT/CAREGIVER RESPONSE TO EDUCATION: WRITE RESPONSE IN CODE SPACE BEFORE THE AREA EDUCATED: PATIENT/CAREGIVER RESPONSE CODES: 1-Partial understanding 2-Verbalizes Understanding 3-Returns Demonstration 4-Needs further Education 5-Goals met

# THERAPEUTIC EXERCISES	#PULMONARY THERAPY	#MUSCLE RE-EDUCATION	#HOME EXERCISE PROGRAM
_____ Teach Exercises	_____ Teach Breathing Exercises	_____ Teach Muscle Re-Education for:_____	_____ Teach HEP
_____ Balance Instruction	_____ Teach postural Drainage	_____ Teach:_____	#OTHER
_____ Coordination Instruction	_____ Teach Chest Percussion	#PROSTHETIC/ORTHOTIC TRAINING	_____ Teach Safety
# TRANSFER TRAINING	_____	_____ Teach Stump Care	_____ Teach Equipment use
_____ Teach Supine/Sit	Teach:_____	_____ Teach Prosthetic Fit	_____ Teach Energy Conservation
_____ Teach Sit/Stand	#GAIT TRAINING/MOBILITY	#ELECTRO THERAPY	_____ Teach Pain Management
_____ Teach Toilet/Bed/Chair	_____ Teach WB Status	_____ Teach TENS use	_____ Teach Joint Precaution
_____ Teach Bed mobility	_____ Teach Ambulation		_____ Teach Body mechanics
_____ Teach:_____	_____ W/C Mobility		

SUPERVISION ☐ Aide ☐ PTA Present: ☐ YES ☐ NO
Care Plan Followed: ☐ YES ☐ NO
Care Plan revised: ☐ YES ☐ NO
Progress Towards Goals: ☐ YES ☐ NO
Patient/Caregiver satisfied with care: ☐ YES ☐ NO

MEDICATIONS/REVISIONS
☐ Medication Regime Assessed ☐ RN Managing Medication Regime
☐ New/Changed Orders_____
☐ Pt/S/O aware
☐ Med Profile/Care Plan Updated

COORDINATION OF SERVICES
☐ Communication/Case Conference with
Phys/PCC/Sch/Other:_____Regarding_____
☐ Universal Precautions ☐ New Orders Received_____☐ Mod Written
Physician Next Visit:_____ Next Therapy Visit:_____ DISCHARGE PLANNING ☐ In Progress ☐ Complete

PATIENT/REPRESENTATIVE, PLEASE SIGN AND DATE TO CONFIRM THE TIME AND DATE OF THE PHYSICAL THERAPY VISIT STATED BELOW

Signature of patient or Acting Representative Relationship

X

Therapist's Signature Date: Time In: Time Out:

Patient Name (Print) Identified by:

Last First