BRIGHTSTAR CARE

PHYSICAL THERAPY EVALUATION and TREATMENT PLAN

INSTRUCTIONS: This form must be completed by a licensed professional Physical Therapist. Refer to the back side of the form for Objective Data Tests and Scales.

PERTINENT BACKGROUND INFORMATION

Facility _____

Resident _____ Room No. _____ Admission date ___/___/___ D.O.B. ___/___/___

Medicare No. _____ ☐ Part A ☐ Part B Other insurance _____

Treatment diagnosis _____ ICD-9 code _____ Onset ___/___/___

MD referral and date _____ Date plan established ___/___/___

Prior level of function _____

Prior living situation/support system _____

Describe pertinent medical/social history and/or previous therapy provided: _____

MUSCLE STRENGTH/FUNCTIONAL ROM EVALUATION

	AREA	STRENGTH RIGHT	STRENGTH LEFT	ACTION	ROM RIGHT	ROM LEFT
UPPER EXTREMITIES	Shoulder			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Elbow			Flex/Extend		
	Forearm			Sup./Pron.		
	Wrist			Flex/Extend		
	Fingers (Grip)			Flex/Extend		
LOWER EXTREMITIES	Hip			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Knee			Flex/Extend		
	Ankle			Plant./Dors.		
	Foot			Inver./Ever.		

ADDITIONAL SKIN/MUSCLE EVALUATION CRITERIA

TRUNK/NECK/POSTURE _____

MUSCLE TONE _____

SPECIFIC DEFICITS _____

_____

PALPATION _____

SKIN CONDITION _____

EDEMA _____

REHAB POTENTIAL _____

PAIN: ☐ Intermittent ☐ Variable ☐ Constant

Intensity scale: 1 _____ 10

FUNCTIONAL INDEPENDENCE/BALANCE EVALUATION

	TASK		ASSIST GRADE	ASSISTIVE DEVICES/ COMMENTS
BED MOBILITY	Roll/turn			
	Sit/supine			
	Scoot/bridge			
TRANSFERS	Sit/stand			
	Bed/wheelchair			
	Toilet			
	Floor			
	Auto			
BALANCE	Sit	Static		
		Dynamic		
	Stand	Static		
		Dynamic		
W/C SKILLS	Propulsion			
	Weight shift			
	Foot rests			
	Brakes			

ADDITIONAL FUNCTIONAL EVALUATION CRITERIA

ENDURANCE _____

COGNITION: ☐ Alert ☐ Oriented x_____ ☐ Confused

☐ Comatose ☐ Agitated ☐ Lethargic

☐ Good judgement in regards to safety

☐ ST Memory ☐ LT Memory

☐ Follows _____ step commands

VISION _____ HEARING _____ SPEECH _____

PROPRIOCEPTION _____ COORDINATION _____

GAIT ANALYSIS

ASSIST _____ DEVICE _____

GAIT ANALYSIS _____

_____

WEIGHT BEARING STATUS _____ LEG LENGTH _____

NAME–Last	First	Middle	Attending Physician	Record No	Room/Bed