FIRST HEALTH SYSTEMS

PHYSICAL THERAPY REVISIT NOTE

VITAL SIGNS: Temperature:________ Pulse:________ ☐ Regular ☐ Irregular Respirations:________ ☐ Regular ☐ Irregular
Blood Pressure: Right____/____ Left____/____ ☐ Lying ☐ Standing ☐ Sitting
Pain: ☐ None ☐ Same ☐ Improved ☐ Worse Origin________ Location(s)________
Duration________ Intensity 0-10____ Other________ Relief measures________

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify)________

TYPE OF VISIT:
☐ Revisit
☐ Revisit and Supervisory Visit
☐ Other (specify)________

TREATMENT DIAGNOSIS/PROBLEM ________

EXPECTED TREATMENT OUTCOME(S) ________

PHYSICAL THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X".)

	Evaluation (B1)		Balance training/activities		Management and evaluation of care plan (B12)		Teach safe/effective use of adaptive/assist device (specify)
	Establish / Upgrade home exercise program		TENS		Pulmonary Physical Therapy (B6)		
	☐ Copy given to patient		Ultrasound (B7)		Cardiopulmonary PT		Teach safe stair climbing skills
	☐ Copy attached to chart		Electrotherapy (B8)		Pain Management		Other:
	Patient/Family education		Prosthetic training (B9)		CPM (specify)		
	Therapeutic exercise (B2)		Preprosthetic training		Functional mobility training		
	Transfer training (B3)		Fabrication of orthotic device (B10)		Teach bed mobility skills		
	Gait training (B5)		Muscle re-education (B11)		Teach hip safety precautions		

ROM: ________
STRENGTH: ________
BALANCE: ________
AMBULATION: ________
ASSESSMENT: ________

SAFETY ISSUES
☐ Obstructed pathways
☐ Home environment
☐ Stairs ☐ Unsteady gait
☐ Verbal cues required
☐ Equipment in poor condition
☐ Bathroom ☐ Commode
☐ Others:________

CARE PLAN: ☐ Reviewed/Revised with patient involvement.
If revised, specify________

☐ Need for referral (specify)________

PLAN FOR NEXT VISIT________

DISCHARGE PLANS DISCUSSED WITH: ☐ Patient/Family ☐ Care Manager ☐ Physician ☐ Other (specify)________
BILLABLE SUPPLIES RECORDED? ☐ N/A ☐ Yes (specify)________

CARE COORDINATION: ☐ Physician ☐ PT/PTA ☐ OT ☐ SLP ☐ MSW ☐ SN ☐ HHA ☐ Other (specify)________

SUPERVISORY VISIT (Complete if applicable)
☐ PT Assistant ☐ Aide / ☐ Present ☐ Not present
SUPERVISORY VISIT: ☐ Scheduled ☐ Unscheduled
OBSERVATION OF________

TEACHING/TRAINING OF________

PATIENT/FAMILY FEEDBACK ON SERVICES/CARE (specify)________

NEXT SCHEDULED SUPERVISORY VISIT________
CARE PLAN UPDATED? ☐ No ☐ Yes (specify)________

If PT assistant/aide **not present,** specify date he/she was contacted regarding updated care plan: ____/____/____

SIGNATURES/DATES

X________ ____/____/____
Patient/Caregiver (if applicable) *Date*

Complete TIME OUT prior to signing below.
________ ____/____/____
Therapist (signature/title) *Date*

TIME IN______ TIME OUT______

PATIENT NAME – Last, First, Middle Initial | ID#

Form 3578P © 1994 Briggs Corporation, Des Moines, IA 50306 www.BriggsCorp.com
To order, phone 1-800-247-2343 PRINTED IN U.S.A