H & M Health Services, Inc.

PHYSICAL THERAPY EVALUATION

OBJECTIVE DATA TESTS AND SCALES PRINTED ON REVERSE.

DATE OF SERVICE: ____/____/____

HOMEBOUND REASONS: ☐ Needs Assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go 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 EVALUATION
☐ Initial ☐ Recertification ☐ ROC

SOC DATE: ____/____/____
(Complete Physical Therapy Care Plan)

PATIENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEMS: _____

ONSET/EXACERBATION DATE: ____/____/____

MEDICAL HISTORY

☐ Hypertension ☐ Fractures ☐ CVA
☐ Cardiac ☐ Cancer ☐ Osteoarthritis
☐ Diabetes ☐ Infection ☐ Psychosis
☐ Respiratory ☐ Immunosuppressive ☐ Parkinson
☐ Osteoporosis ☐ Open wound
☐ Surgeries: _____
☐ Other (specify): _____

HISTORY OF PRESENT ILLNESS SOCIAL HISTORY AND/OR PREVIOUS THERAPY RECEIVED AND OUTCOMES

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

LIVING SITUATION

☐ Capable ☐ Able ☐ Willing caregiver available
☐ Limited caregiver support (available/willingness)
☐ No caregiver available

HOME SAFETY BARRIERS:
☐ Clutter ☐ Throw rugs ☐ Needs grab bars ☐ Needs railings
☐ Steps (number/condition): _____
☐ Other (specify): _____

PRIOR LEVEL OF FUNCTION

ADLs:
☐ Independent ☐ Needed assistant (level): _____ ☐ Unable
Equipment used: _____

IN-HOME MOBILITY (gait or wheelchair/scooter):
☐ Independent ☐ Needed assistance (level): _____ ☐ Unable
Equipment used: _____

COMMUNITY MOBILITY (gait or wheelchair/scooter):
☐ Independent ☐ Needed assistance (level): _____ ☐ Unable
Equipment used: _____

BEHAVIOR/MENTAL STATUS

☐ Alert ☐ Oriented ☐ Cooperative
☐ Confused ☐ Memory deficits ☐ Impaired judgment
☐ Other (specify): _____

PAIN

INTENSITY: 0 1 2 3 4 5 6 7 8 9 10
LOCATION: _____
AGGRAVATING FACTORS: _____
_____
RELIEVING FACTORS: _____
_____
ACCEPTABLE LEVEL OF PAIN: _____

VITAL SIGNS/CURRENT STATUS

BP: _____ Pulse: _____ Respiration: _____ Temp: _____
O_2 saturation _____% (when ordered): ☐ at rest ☐ with activity
Endurance: _____
Vision: _____ Hearing: _____
Edema: _____
Skin: _____
_____
Sensation: _____
Posture: _____
Muscle Tone:

HIGH RISK FACTORS

☐ Falls ☐ Cognitive Impairment ☐ Circulatory Impairment
☐ Sensory Loss ☐ Cardiac ☐ Respiratory Impairment
☐ High Alert Meds: _____
☐ Other _____

PATIENT/CLIENT NAME: (*Last, First , Middle Initial*) ☐ Patient Identifiers Confirmed: ☐ *DOB* ☐ *Caregiver* ☐ *Picture ID*

Patient I.D. #:

PHYSICAL THERAPY EVALUATION (CONT'D)

MUSCLE STRENGTH/FUNCTIONAL ROM EVALUATION

	AREA	STRENGTH Right	STRENGTH Left	ACTION	ROM Right	ROM Left
UPPER EXTREMITY	Shoulders			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Elbow			Flexion		
				Extension		
	Forearm			Sup./Pron.		
	Wrist			Flex/Extend		
	Fingers			Flex/Extend		
LOWER EXTREMITIEY	Hip			Flex/Extend		
				Int. rot./Ext. rot.		
				Abd. /Add.		
	Knee			Flexion		
				Extension		
	Ankle			Plant. /Dors.		
	Foot			Inver. /Ever.		
SPINE	AREA	STRENGTH		ACTION	ROM	

FUNCTIONAL INDEPENDENCE/BALANCE EVAL

	TASK	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS
BED MOBILITY	Roll/Turn		
	Sit/Supine		
	Scoot/Bridge		
TRANSFERS	Sit/Stand		
	Bed/Wheelchair		
	Toilet		
	Shower		
	Auto		
BALANCE	Static Sitting		**TUG:** _____ Seconds
	Dynamic Sitting		**TINETTI:** _____/28 (Assistive device used):_____
	Static Standing		
	Dynamic Standing		**DGI:** _____/12 (Assistive device used): _____
			Other:
W/C SKILLS	Propulsion		
	Pressure Reliefs		
	Foot Rests		
	Locks		
	Wheelchair Mobility		

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength – against gravity – full resistance.
4	Good strength – against gravity – no resistance.
3	Fair strength – against gravity – no resistance – safety compromise.
2	Poor strength – unable to move against gravity.
1	Trace strength – slight muscle contraction – no motion.
0	Zero – no active muscle contraction.

STANDARDIZED BALANCE/FALL RISK TESTS

DESCRIPTION
TUG (Timed Up and Go): Greater than 14 seconds the patient is risk for fall.
TINETTI (Balance and Gait): Under 19 = High risk of falls 20 – 24 = Moderate risk; 24 and up = Low risk.
DGI (Dynamic Gait Index): > 9 = Increased fall risk.

FUNCTIONAL INDEPENDENCE SCALE (bed mobility, transfers, balance, W/C skills)

GRADE	DESCRIPTION
5	Independent **(I)** – physically able and independent.
4	Verbal cues **(VC)** only needed.
3	Stand-by assist **(SBA)** – 100% patient/client effort.
2	Minimum assistant **(Min A)** – 75% of patient/client effort.
1	Maximum assistant **(Max A)** – 25% - 50% patient/client effort.
0	Totally dependent – total care/support.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	100% of active functional motion.
4	75% of active functional motion.
3	50% of active functional motion
2	25% of active functional motion.
1	Less than 25%.

GAIT

ASSISTANCE: ☐ Independent ☐ SBA ☐ Min. assist ☐ Mod. assist ☐ Max. assist ☐ Unable

SURFACES: ☐ Level ☐ Uneven ☐ stairs (number/condition)_____ DISTANCE/TIME:_____

WEIGHT BEARING STATUS: ☐ FWB ☐ WBAT ☐ PWB ☐ TTWB ☐ NWB

ASSISTIVE DEVICE(S): ☐ Cane ☐ Quad Cane ☐ Crutches ☐ Hemi Walker ☐ Front Wheel Walker ☐ Other (specify):_____

QUALITY/DEVIATION/POSTURE:

SUMMARY

Instruction Provided: ☐ Safety ☐ Exercise ☐ Other (describe): _____

EQUIPMENT (available): _____(condition): _____(needs): _____

☐ PT Evaluation only (reasons for no further visit planned): ☐ Patient refused ☐ Not home bound ☐ Optimal level of function ☐ Cognitive deficits

☐ Other (specify):

DISCHARGE DISCUSSED WITH: ☐ Patient/Caregiver ☐ Family ☐ Physician ☐ Other (specify): _____

CARE COORDINATION: ☐ Physician ☐ SN ☐ PTA ☐ OT ☐ ST ☐ MSW ☐ Aide ☐ Other (specify):

PRINT PATIENT NAME: *(LAST, FIRST)*	**PATIENT/CAREGIVER** ***Signature:***
PRINT THERAPIST NAME:	**THERAPIST SIGNATURE:**

MR #:	**TIME IN:** **TIME OUT:**	**DATE:**

H & M Health Services, Inc.

PHYSICAL THERAPY SERVICE ORDER/CARE PLAN

☐ Telephone Order *(Physician signature required)* Date of Telephone Order: _____

PATIENT NAME:	Patient I.D. #:
Physician Name:	Assessment Date:
Therapist Assigned:	Planned D/C Date:
Frequency/Duration:	Onset/Exacerbation Date:
Treatment Diagnosis(es)/Problems:	

Type of Evaluation *(please check one)*: ☐ New Admission ☐ Resumption of Care ☐ Recertification of Care

THERAPEUTIC INTERVENTION TO BE CONTINUED *(Mark all applicable with an "X")*

☐ Evaluation/Reevaluation (B1)	☐ Transfer training (B3)	☐ Preprosthetic training	☐ Pain Management
☐ Establish/Upgrade home exercise program (B4)	☐ Muscle strengthening	☐ Prosthetic training (B9)	☐ TENS
☐ Copy given to patient	☐ Teach bed mobility skills	☐ Teach safe/effective use of adaptive/assistive device (specify):	☐ Ultrasound (B7) @ _____ w/cm2
☐ Copy placed in folder	☐ Functional mobility training		8 – 10 mins to (area): _____
☐ Patient/Family education	☐ Balance training/activities	☐ Management and evaluation of care plan (B 12)	☐ Electrotherapy (B8)
☐ Therapeutic exercises (B2)	☐ Teach safety precautions		☐ Manual Therapy (specify):
☐ Gait training (B 5)	☐ Home Safety	☐ Teach fall prevention	
☐ Teach safety stairs climbing skills	☐ Neuro- muscular re-education (B11)	☐ Other:	☐ Teach application of Heat/Cold

REHAB POTENTIAL/DISCHARGE PLANS *(Mark all applicable with an "X")*

☐ **Rehab Potential:** Good with Patient able to return to previous level of activity and improvement in functional status in accordance with Patient's endurance level.	☐ **Rehab Potential:** Good for stated goals.	☐ **Discharge Plan:** Patient will be discharged when Patient is able to function independently within current limitations at home.
☐ **Rehab Potential:** Good for Patient to be able to follow the plan or care/treatment regimen, and be able to self manage his/her condition.	☐ **Rehab Potential Guarded:** Minimal improvement in functional status expected and decline is possible.	☐ **Discharge Plan:** Patient will be discharged when Patient is able to function with assistance of caregiver within current limitations at home.
☐ **Rehab Potential Fair:** Patient will develop functional mobility within the home care setting.	☐ **Other:**	☐ **Discharge Plan:** Patient will be discharged from Physical Therapy when Patient has met Optimal Rehab potential and/or stated goals are met.

PHYSICAL THERAPY GOALS

☐ Patient will increase muscle strength in _____ to _____/5 in _____ ☐ weeks ☐ visits

☐ Patient will increase AROM in _____ to _____° in _____ ☐ weeks ☐ visits

☐ Patient will increase gait to _____ feet with _____ assist with _____ (assistive device) in _____ ☐ weeks ☐ visits

☐ Patient will be able to climb stairs/walk on uneven surfaces with _____ assist in order to safely leave home with _____ assist in _____ ☐ weeks ☐ visits.

☐ Patient will improve bed mobility with _____ assist in _____ ☐ weeks ☐ visits

☐ Patient will improve (specify surface) _____ transfer with _____ assist using (AD) _____ in _____ ☐ weeks ☐ visits

☐ Patient will demonstrate improved ☐ sitting ☐ standing balance ☐ static ☐ dynamic to _____/5 In _____ ☐ weeks ☐ visits in order to decrease risk for falls.

☐ Patient/caregiver will demonstrate proper use and care of prosthetic/orthotic devices in _____ ☐ weeks ☐ visits

☐ Patient will verbalize/and or demonstrate increased safety awareness in _____ ☐ weeks ☐ visits to decrease risk of falls.

☐ Patient/caregiver will verbalize/and or demonstrate fall prevention techniques _____ ☐ weeks ☐ visits

☐ Patient will verbalize pain relief from _____/10 to _____/10 in _____ ☐ weeks ☐ visits

☐ Patient/Caregiver will demonstrate the ability to follow H.E.P in _____ ☐ weeks ☐ visits

☐ Patient will show a decrease in fall risk by an improvement in: ☐ TUG score to _____ seconds ☐ Tinetti Balance/Gait score to _____/28

☐ DGI score to _____/12 ☐ MCTSIB _____/4 in _____ ☐ weeks ☐ visits

☐ Other:

60 Day Summary *(Recertification only)*: _____

Dr. _____ may also write orders for the care of this patient.

I have read the above evaluation and approve of the Plan of Care:

Physician Signature: _____ Date: _____

Therapist Signature: _____ Date: _____