RHC™
Recovery Home Care

PHYSICAL THERAPY EVALUATION

DATE OF SERVICE ___/___/___

TIME IN _____ **OUT** _____

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 EVALUATION: ☐ Initial (complete Care Plan) ☐ Interim ☐ Final

SOC DATE ___/___/___

PT ORDERS: ☐ Evaluation ☐ Therapeutic Exercise ☐ Transfer Training ☐ Home Program Instruction ☐ Gait Training ☐ Chest PT ☐ Muscle Re-education ☐ Electrotherapy ☐ Prosthetic Training ☐ Ultrasound ☐ Other:

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEM _____

ONSET ___/___/___

MEDICAL HISTORY

☐ Hypertension ☐ Cardiac ☐ Diabetes ☐ Respiratory ☐ Osteoporosis ☐ Fractures ☐ Cancer ☐ Infection ☐ Immunosuppressed ☐ Open wound ☐ Other (specify)

PRIOR LEVEL OF FUNCTION

ADLs:
☐ Independent ☐ Needed assistance ☐ Unable ☐ Equipment used: _____

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

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

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY RECEIVED AND OUTCOMES

LIVING SITUATION

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

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

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/RELIEVING FACTORS: _____

VITAL SIGNS/CURRENT STATUS

BP: _____ T.P.R.: _____ Edema: _____ Sensation: _____
Skin Condition: _____ Muscle Tone: _____ Posture: _____
Communication: _____ Vision: _____ Hearing: _____
Endurance: Orthotic/Prosthetic Devices:

PATIENT INFORMATION

PATIENT/CLIENT NAME – Last, First, Middle Initial	ID#

MUSCLE STRENGTH/FUNCTIONAL ROM EVAL

	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			Flex/Extend		
LOWER EXTREMITIES	Hip			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Knee			Flex/Extend		
	Ankle			Plants./Dors.		
	Foot			Inver/Ever		

FUNCTIONAL INDEPENDENCE/BALANCE EVAL

	TASK	ASSIST SCORE	ASSISTIVE DEVICES / COMMENTS
BED MOBILITY	Roll/Turn		
	Sit/Supine		
	Scoot/Bridge		
TRANSFERS	Sit/Stand		
	Bed/Wheelchair		
	Toilet		
	Floor		
	Auto		
BALANCE	Static Sitting		
	Dynamic Sitting		
	Static Standing		
	Dynamic Standing		
W/C SKILLS	Propulsion		
	Pressure Reliefs		
	Foot Rests		
	Locks		

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 with some 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.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

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

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

GRADE	DESCRIPTION
5	Physically able and does task independently.
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) – 100% patient/client effort.
2	Minimum assist (Min A) – 75% patient/client effort.
1	Maximum assist(Max A) – 25% - 50% patient/client effort.
0	Totally dependent – total care/support.

BALANCE SCALE (sitting – standing)

GRADE	DESCRIPTION
5	Independent
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) – 100% patient/client effort.
2	Minimum assist (Min A) – 75% patient/client effort.
1	Maximum assist (Max A) – 25% - 50% patient/client effort.
0	Totally dependent for support

NORMATIVE DATA FOR JOINT MOTION (ROM)

AREA	ACTION/MOVEMENT			
Shoulder	Flex	158°	Extend	55°
	Abd.	170°	Add.	50°
	Int. rot.	70°	Ext. rot.	90°
Elbow	Flex	145°	Ext.	0°
Forearm	Sup.	85°	Pron.	70°
Wrist	Flex	73°	Ext.	70°
Fingers	Flex all	90°	Ext.	0°
Hip	Flex	90°-115°	Ext.	25°
	Abd.	45°	Add.	30°
	Int. rot.	45°	Ext. rot.	45°
Knee	Flex	135°	Ext.	10°
Ankle	Plant.	50°	Dors.	20°
Foot	Inv.	30°	Ever.	20°

GAIT

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

SURFACES: ☐ Level ☐ Uneven ☐ Stairs (number/condition) _____ **DISTANCE:** _____

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

ASSISTIVE DEVICE(S): ☐ Cane ☐ Quad cane ☐ Crutches ☐ Hemi-walker ☐ Walker ☐ Wheeled walker ☐ Other (specify) _____

QUALITY/DEVIATIONS:

EQUIPMENT

HAS:

NEEDS:

SIGNATURE & DATE

PATIENT/CLIENT SIGNATURE & DATE ____/____/____

THERAPIST'S SIGNATURE/TITLE & DATE (Complete TIME OUT on front prior to signing) ____/____/____

RHC™
Recovery Home Care

PHYSICAL THERAPY CARE PLAN

SOC DATE ___/___/___

DIAGNOSIS _____ **ONSET** ___/___/___

PROBLEM(S) _____

PATIENT/CLIENT DESIRED OUTCOMES	SHORT TERM OUTCOMES Time Frame	LONG TERM OUTCOMES Time Frame

PLAN OF CARE (Mark all applicable with an "X".)

☐ Evaluation	☐ Pulmonary Physical Therapy	☐ CPM (specify)
☐ Establish rehab. Program	☐ Ultrasound	☐ Functional mobility training
☐ Establish home exercise program	☐ Electrotherapy	☐ Teach bed mobility skills
☐ Copy given to patient/client	☐ Prosthetic training	☐ Teach hip safety precautions
☐ Copy attached to chart	☐ Preprosthetic training	☐ Teach safe/effective use of adaptive/ assist
☐ Patient/Client/Family education	☐ Fabrication of orthotic device	☐ device (specify)
☐ Therapeutic exercise	☐ Muscle re-education	☐ Teach safe stair climbing skills
☐ Transfer training	☐ Management and evaluation of care plan	☐ Other:
☐ Home program Establish/Upgrade	☐ TENS	☐
☐ Gait training	☐ Cardiopulmonary PT	☐
☐ Balance training/activities	☐ Pain Management	☐

FREQUENCY _____ **REHAB POTENTIAL** ☐ Good ☐ Fair ☐ Poor

MODALITIES _____

EQUIPMENT RECOMMENDATIONS _____

SAFETY ISSUES/INSTRUCTION/EDUCATION

COMMENTS/ADDITIONAL INFORMATION _____

PATIENT/CLIENT/CAREGIVER RESPONSE TO PLAN OF CARE _____

CARE COORDINATION: ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST ☐ SW ☐ Other (specify) _____

PLAN FOR NEXT VISIT _____

PLAN DEVELOPED BY (signature/title/date) _____ ___/___/___

CARE PLAN REVIEW

PART 1 – Clinical Record **PART 2 – Patient's Residence**

PATIENT/CLIENT NAME – Last, First, Middle Initial	ID#

Recovery Home Care Physical Therapy Addendum to Evaluation

ADL/IADLs

For M0640-M0800, complete the "Current" column for all patients. For these same items, complete the "Prior" column only at start of care and at resumption of care; mark the level that corresponds to the patient's condition 14 days prior to start of care date (M0030) or resumption of care date (M0032). In all cases, record what the patient is *able to do*.

(M0640) Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

Prior	Current		
☐	☐	0	- Able to groom self unaided, with or without the use of assistive devices or adapted methods.
☐	☐	1	- Grooming utensils must be placed within reach before able to complete grooming activities.
☐	☐	2	- Someone must assist the patient to groom self.
☐	☐	3	- Patient depends entirely upon someone else for grooming needs.
☐		UK	- Unknown

(M0650) Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Prior	Current		
☐	☐	0	- Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
☐	☐	1	- Able to dress upper body without assistance if clothing is laid out or handed to the patient.
☐	☐	2	- Someone must help the patient put on upper body clothing.
☐	☐	3	- Patient depends entirely upon another person to dress the upper body.
☐		UK	- Unknown

(M0660) Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Prior	Current		
☐	☐	0	- Able to obtain, put on, and remove clothing and shoes without assistance.
☐	☐	1	- Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
☐	☐	2	- Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
☐	☐	3	- Patient depends entirely upon another person to dress lower body.
☐		UK	- Unknown

(M0670) Bathing: Ability to wash entire body. **Excludes grooming (washing face and hands only).**

Prior	Current		
☐	☐	0	- Able to bathe self in shower or tub independently.
☐	☐	1	- With the use of devices, is able to bathe self in shower or tub independently.
☐	☐	2	- Able to bathe in shower or tub with the assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas.
☐	☐	3	- Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
☐	☐	4	- Unable to use the shower or tub and is bathed in bed or bedside chair.
☐	☐	5	- Unable to effectively participate in bathing and is totally bathed by another person.
☐		UK	- Unknown

(M0680) Toileting: Ability to get to and from the toilet or bedside commode.

Prior	Current		
☐	☐	0	- Able to get to and from the toilet independently with or without a device.
☐	☐	1	- When reminded, assisted, or supervised by another person, able to get to and from the toilet.
☐	☐	2	- Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
☐	☐	3	- Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
☐	☐	4	- Is totally dependent in toileting.
☐		UK	- Unknown

(M0690) Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior	Current		
☐	☐	0	- Able to independently transfer.
☐	☐	1	- Transfers with minimal human assistance or with use of an assistive device.
☐	☐	2	- Unable to transfer self but is able to bear weight and pivot during the transfer process.
☐	☐	3	- Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
☐	☐	4	- Bedfast, unable to transfer but is able to turn and position self in bed.
☐	☐	5	- Bedfast, unable to transfer and is unable to turn and position self.
☐		UK	- Unknown

(M0700) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior	Current		
☐	☐	0	- Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
☐	☐	1	- Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
☐	☐	2	- Able to walk only with the supervision or assistance of another person at all times.
☐	☐	3	- Chairfast, unable to ambulate but is able to wheel self independently.
☐	☐	4	- Chairfast, unable to ambulate and is unable to wheel self.
☐	☐	5	- Bedfast, unable to ambulate or be up in a chair.
☐		UK	- Unknown

(MO 825) **therapy need:** Does the care plan of the Medicare payment period for which this assessment will define a case mix group indicate a need for therapy (physical, occupational, or speech therapy) that meets the threshold for a Medicare high-therapy case mix group?

☐ - No
☐ - Yes
☐ - NA not applicable

What is the primary diagnosis that you will be treating. _____

_____