RHC™ Recovery Home Care

SPEECH THERAPY REVISIT NOTE

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 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	☐ Aural rehabilitation	☐ Speech dysphagia instruction program
☐ Establish rehab. Program	☐ Non-oral communication	☐ Care of voice prosthesis including removal, cleaning, site maintenance
☐ Establish home exercise program	☐ Alaryngeal speech skills	
☐ Copy given to patient/client	☐ Language processing	☐ Teach/Develop communication system
☐ Copy attached to chart	☐ Food texture recommendation	☐ Trach. instruction and care
☐ Patient/Client/Family education	☐ Safe swallowing evaluation	☐ Other:
☐ Voice disorders	☐ Therapy to increase articulation, proficiency, verbal expression	
☐ Speech articulation disorders		
☐ Dysphagia treatments	☐ Lip, tongue, facial exercises to improve swallowing/vocal skills	
☐ Langauge disorders		

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES _____

EVALUATION AND PATIENT /CLIENT/CAREGIVER RESPONSE _____

CARE PLAN: ☐ Reviewed/Revised with patient/client involvement. If revised, specify _____

☐ Outcome/Instruction achieved (describe) _____

PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ☐ Patient/Client/Family ☐ Physician ☐ Care Manager

☐ Other (specify) _____

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

SUPERVISORY VISIT (Complete if applicable)

☐ HHA/CNA _____

OBSERVATION OF _____

TEACHING/TRAINING OF _____

FOLLOWING CARE PLAN? ☐ Yes ☐ No CARE PLAN UPDATED? ☐ Yes ☐ No

PATIENT SATISFIED WITH SERVICES? ☐ Yes ☐ No (If No, please explain) _____

SIGNATURES/DATES

Complete **TIME OUT** (above) prior to signing below.

X _____ ___/___/___ _____ ___/___/___

Patient/Client/Caregiver (if applicable) Date Therapist (signature/title) Date

PART 1 – Clinical Record PART 2 - Billing

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