REGAL HOME SERVICES

MIAMI OFFICE
18260 NE 19th Ave Suite 104
North Miami Beach, FL 33162
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BROWARD OFFICE
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Sunrise, FL 33313
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BOCA OFFICE
3350 NW 2nd Ave Suite A-42
Boca Raton, FL 33431
T: S61-395-0505 F: 561-39S-0506

☐ PT ☐ OT

THERAPY NOTE

PATIENT'S NAME: _____ DATE: _____ TIME(IN & OUT) _____

ACTIVITIES PERMITTED:

___ Complete Bed Rest. ___ Bed Rest/BRP. ___ Transfer Bed/Chair. ___ Up As Tolerated. ___ Full Weight Bearing
___ Partial Weight Bearing. ___ No Weight Bearing. ___ Independent At Home. ___ No Restrictions. ___ Wheel Chair
___ Walker. ___ Cane. ___ Crutches. ___ Hoyer Lift. ___ Stair Climbing. ___ Other: _____

MENTAL STATUS:

___ Oriented. ___ Forgetful. ___ Disoriented. ___ Agitated. ___ Comatose. ___ Depressed. ___ Lethargic.
___ Other:_____.

PATIENT'S PHYSICAL STATUS:

___ Bed Bound. ___ Severe SOB. ___ Ambulates with Assist. ___ Uses W/C, Walker, Cane. ___ Up in Chair/Max Assist
___ Severe Weakness. ___ Paralysis. ___ Unable to Walk. ___ Balance/Gait-Unsteady. ___ Other: _____

Subjective Comments: _____

_____

Specific Safety Issues Addressed: _____

_____

TREATMENTS RENDERED:	INSTRCUTED: PT	CG
☐ Assessment:	___	___
☐ Therapeutic Exercises:	___	___
☐ Bed Mobility:	___	___
☐ Transfer Training:	___	___
☐ Gait Training:	___	___
☐ Endurance:	___	___
☐ Joint Mobility:	___	___
☐ Motor Assessment:	___	___

PLAN OF CARE: (Action/Progress toward Goals ad PT's Response to Instructions)

_____

_____

_____

_____

_____

Interdisciplinary Communication: ___ RN. ___ PT. ___ PTA. ___ OT. ___ SLP. ___ MSW. ___ HHA. ___ MD.
Date/Describe: _____
Next Scheduled Visit Date: _____
Plan for Next Visit: _____
Additions to Plan of Care: _____

THERAPIST NAME/TITLE: _____ SIGNATURE: _____

Patient's Signature: _____