SOUTHEAST HOMECARE CORP — THERAPY EVALUATION

PATIENT NAME | M.R.# | H.I.C. #

DIAGNOSIS/DATE ONSET:

REFERRED TO: (Circle) RN MSW ST OT HHA

LEFT SPAS/SYN	STR	ROM	PART		ROM	STR	RIGHT SPAS/SYN
			SCAP	elev.			
				Depress			
				Protract			
				Retract			
			SH	flex			
				Ext			
				Abd			
				Add			
				I. Rot			
				E. Rot			
			ELBOW	Flex			
				Ext			
			WRIST	Flex			
				Ext			
				Sup			
				Pron			
			HIP	flex			
				Ext			
				Abd			
				Add			
				I. Rot			
				E. Rot			
			KNEE	flex			
				Ext			
			ANKLE				
				Dorsal-Flex			
				Pl. Flex			
				Inver			
				Ever			
			CERV	flex			
				Ext			
				Rot			
			TRUNK	flex			
				Ext			
				Rot			

NEUROLOGICAL ASSESSMENT

Pain _____

Reflexes _____

Other _____

Dresses self

Feeds self

Bathes self

Sitting balance

Static standing balance

Dynamic standing balance

Transfers:

Bed Mobility:

Gets in and out of tub/shower

GAIT EVALUATION

Climb Steps

Architectural Barriers

Clinical Findings Summary

Prior level:

DME present/needed

Obstacles:

Lighting:

Placement of furniture:

Homebound Status

LIMITATIONS OF HAND AND FOOT:

S.O./Pt. UNDERSTANDING

EMERGENCY PLAN:

P.T. GOALS:

REHAB POTENTIAL TO ACHIEVE GOALS REASON

FREQUENCY/DURATION

TREATMENT:

INITIAL TREATMENT

PRINTED NAME_____ TITLE_____ SIGNATURE _____ DATE _____

SOUTHEAST HOMECARE CORPORATION

PATIENT'S NAME: _____ D/O/B_____ EVAL DATE: _____

PARAMEDICAL GOALS/REHAB/DISCHARGE PLAN
PHYSICAL THERAPY

[ ] Pt. will exhibit indep. in safe transfers and ambulation with/without device (specify: cane, quad cane, walker, rolling walker, wheel chair) within _____weeks.

[ ] Pt. will verbalize increased pain relief within _____ weeks.

[ ] Pt. will demonstrate increased independence in activities of daily living within _____ weeks.

[ ] Pt. will exhibit increased strength and endurance within _____ weeks.

[ ] Pt. S.O. will comprehend and verbalize injury prevention techniques within _____ weeks.

[ ] Pt. will exhibit increased independence in mobility/independent mobility within _____ weeks.

[ ] Pt./S.O. will demonstrate transfer technique and use of special devices (specify: cane, quad. cane, walker, rolling walker, wheel chair) within _____weeks.

[ ] Pt./S.O. will comprehend and demonstrate home exercise program within _____ weeks.

[ ] _____

[ ] _____

OCCUPATIONAL THERAPY

[ ] Pt. will exhibit maximum level of strength and ROM within disease limits within _____ weeks.

[ ] Pt. will demonstrate increased independence in ADLS within _____ weeks.

[ ] Pt./S.O. will comprehend and verbalize injury prevention techniques within _____ weeks.

[ ] Pt./S.O. will comprehend and demonstrate home exercise program within _____ weeks.

[ ] _____

[ ] _____

SPEECH THERAPY

[ ] Pt. will demonstrate functional communications within _____ weeks.

[ ] Pt. will exhibit maximum verbal & sentence formulation and comprehension within disease limits within _____ weeks.

[ ] Pt. will exhibit increased auditory comprehension skills within _____ weeks.

[ ] Pt. will demonstrate improved writing skills within _____ weeks.

REHABILITATION POTENTIAL

[ ] good- return to previous level of ADLS independently.

[ ] fair- to be able to carry out minimal ADLS with available home support.

[ ] will not be able to carry out ADLS without maximum support

DISCHARGE PLAN

[ ] Patient will be discharged when skilled services are no longer required and patient/caregiver are independent with care.

[ ] and patient is no longer catheter dependent (foley patients only)

[ ] Patient is able to function independently within his/her current limitations at home.

[ ] Patient is able to function with assistance of caregiver within their current limitations at home.

[ ] Caregiver is able to function independently

PLEASE TURN OVER

SOUTHEAST HOMECARE CORPORATION

PATIENT NAME: _____ D/O/B _____ EVAL DATE: _____

HOMEBOUND STATUS

[ ]	POOR COORDINATION	[ ]	LIMITED MOBILITY	[ ]	RLA (R) (L) AKA
[ ]	LEGALLY BLIND	[ ]	RLH (R) (L) HEMIPARESIS	[ ]	RLB (R) (L) BKA
[ ]	POOR BALANCE	[ ]	POOR ENDURANCE	[ ]	GENERALIZED WEAKKNESS
[ ]	INADEQUATE RESPIR FUNCT	[ ]	REQUIRES ASSIST OF	[ ]	VERTIGO
[ ]	WHEELCHAIR BOUND		1 PERSON TO LEAVE HOME	[ ]	MENTAL CONFUSION
[ ]	S.O.B. ON EXERTION	[ ]	PARAPLEGIA	[ ]	PAIN (R)
[ ]	POOR VISION	[ ]	QUADRIPLEGIA	[ ]	PAIN (L)
[ ]	CHEST PAIN ON EXERTION	[ ]	TRANSFERS ONLY	[ ]	UNSTEADY GAIT
[ ]	HARD OF HEARING	[ ]	PAIN	[ ]	OTHER

SOUTHEAST HOMECARE CORPORATION

3355 NW 55 Street
Fort Lauderdale, FL 33309

NAME OF CLIENT | CLIENT I.D. | WEEK ENDING

ADDRESS | CITY | STATE | ZIP

EMPLOYEE AND NUMBER | CLASSIFICATION | LICENSE

Employee: This form is your responsibility. You cannot be paid without a Time Sheet, your signature and client's. Your Nursing Therapy Notes must accompany this Time Sheet.
EMPLOYEE SIGNATURE

X_____
I certify that the hours are my total hours worked during the week and they were properly verified by the client.

DAY	DATE MO/DAY	TIME IN	TIME OUT	TOTAL HOURS	TYPE SERVICE	CLIENT'S INITIALS
MON						
TUE						
WED						
THU						
FRI						
SAT						
SUN						

Total Hours for Week to Nearest 1/4

Clients do NOT pay Agency employees directly; they will be billed weekly. Employees are not authorized to accept, have custody or the use of cash, credit cards or other valuables of Client. Client waives any right to set off against Agency bill the amount of any such cash or other sum advanced to employees. Client's sole remedy and Agency's sole liability for claims of any kind as to the services rendered by employee shall be limited to the amount of compensation paid or the amount available under Agency bond, and failure to give notice in writing of claim within 10 days after occurrence constitutes a waiver by client of all claims. Client recognizes the rights of Agency as the employer and agrees not to employ personnel hereon for a period of 90 days following the termination of this assignment. In the event Client violates the above condition, Client shall pay to Agency upon demand the sum of $1,000.00 in liquidation damages.
Client agrees to terms of Net upon Receipt and to pay interest on unpaid accounts over 30 days at the rate of 1½% per month (Annual Percentage Rate of 18%) or the legal interest, whichever is lower, together with reasonable attorney's fees or costs of collection, not to exceed 30% of balance due.
I certify that the above hours are correct and that the work was performed in a satisfactory manner by Caring, Inc. and agreement by the client to the Terms and Conditions printed above.

Authorized Client's Signature:

WHITE - Office YELLOW - Staff