SOUTHEAST HOMECARE — PHYSICAL THERAPY EVALUATION

DATE OF SERVICE ___/___/___

Patient Name:

Medical Record Number:

HOMEBOUND REASON

☐Needs assistance for all activities ☐Residual weakness ☐Medical restrictions ☐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) ☐Other:
(Specify)_____
Additional Services:_____

BEHAVIOR/MENTAL STATUS

☐Alert ☐Oriented ☐Cooperative ☐Confused ☐Memory deficits: ☐Short term ☐Long Term ☐Impaired judgment ☐Anxious ☐Dependent ☐Depressed ☐Forgetful ☐Non Responsive ☐Non Communicative ☐Requires Min Assistance ☐Requires Considerable Assistance ☐Requires Prompting ☐Thoughts of Death/Suicide ☐Willing to Learn/Improve ☐Lethargic ☐Apathetic ☐Noncompliant ☐Comatose ☐Memory Deficit ☐Impaired Judgment ☐Verbal Disruption ☐Aggression ☐Disruptive ☐Delusional

VITAL SIGNS

B/P	Lying	Sitting	Standing
L	_____	_____	_____
R	_____	_____	_____

Temp:_____ ☐Oral ☐Auxiliary ☐Other:_____
Pulse: ☐Regular ☐Irregular ☐Apical_____ ☐Brachial_____ ☐Radial_____
Resp:_____ ☐Regular ☐Irregular ☐SOB
O_2 @_____ LPM via: ☐Cannula ☐Mask ☐Trach
Current Weight Bearing Status:_____

Name, contact number and relationship of person residing with patient:

MEDICAL INFORMATION

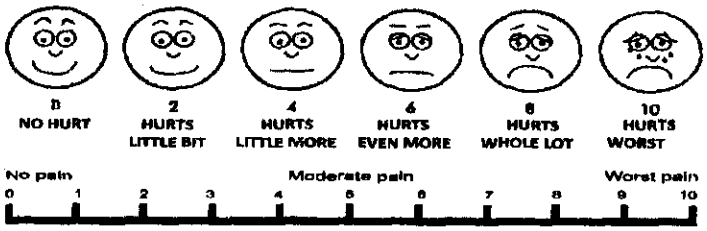
Onset Date:___/___/___
Primary **Diagnosis**:_____
Precautions/Limitations:
☐Hypertension ☐Cardiac ☐Diabetes ☐Respiratory ☐Osteoporosis ☐Fractures ☐Cancer ☐Infection ☐Open Wound ☐Immunosuppressed ☐Alzheimer's ☐Arthritis ☐Hypertension ☐Joint Replacement ☐Kidney ☐Lightheadedness ☐Neuro/CVA ☐Respiratory HX ☐Surgery ☐Vertigo ☐Other:_____
Vision: ☐WNL ☐Blind R/L ☐Visually Impaired ☐Glasses ☐Macular Degeneration
Hearing: ☐WNL ☐Deaf ☐HOH: L/R ☐Aids R/L ☐Tinnitus
Speech: ☐Non Responsive ☐Unable to Express Basic Needs ☐Severe Difficulty Expressing Self ☐Expresses Simple Ideas ☐Minimal Difficulty Expressing Self ☐Expresses Complex Ideas ☐Swallowing Difficulty
☐**Prior Level of Functioning:** _____
ADL's: ☐Independent ☐Needed assist. ☐Total assist.
☐**History of Falls:** ☐Yes/☐No, if yes, date of last fall: ___/___/___

ADL's

Independent Req. Assistance Dependent

	I	RA	D		I	RA	D		I	RA	D		I	RA	D
Grooming	☐	☐	☐	Bathing	☐	☐	☐	Ambulation/Locomotion	☐	☐	☐	Laundry	☐	☐	☐
Ability to Dress Upper Body	☐	☐	☐	Toileting	☐	☐	☐	Feeding or Eating	☐	☐	☐	Housekeeping	☐	☐	☐
Ability to Dress Lower Body	☐	☐	☐	Transferring	☐	☐	☐	Light Meal Preparation	☐	☐	☐	Shopping	☐	☐	☐
								Transportation	☐	☐	☐	Ability to Use Telephone	☐	☐	☐

PAIN



Current Pain Level_____

Best pain gets (0-10):_____ Worst pain (0-10):_____ Acceptable level(0-10):_____
☐Pt has no pain ☐Pt has pain that does not interfere with activity or movement
☐Less often than daily ☐Daily, but not constantly ☐All the time
Pain Description:_____
Pain Location:_____
Frequency: ☐Occasionally ☐Continuous ☐Intermittent
What makes pain worse? ☐Movement ☐Ambulation ☐Immobility
Other:_____
Impacting function? ☐Yes ☐No
What makes pain better? ☐Medication ☐Rest/Relaxation
Other:_____

MUSCLE STRENGTH / FUNCTIONAL ROM EVALUATION

AREA	STRENGTH Right	STRENGTH Left	ACTION	ROM Right	ROM Left
Shoulder			Flex/Extend		
			Adb./Add.		
			Int. Rot./Ext. Rot.		
Elbow			Flex/Extend		
Forearm			Sup./Pron.		
Wrist			Flex/Extend		
Fingers			Flex/Extend		
Hip			Flex/Extend		
			Abd./Add.		
			Int. Rot/Ext. Rot.		
Knee			Flex/Extend		
Ankle			Plant./Dors.		
Foot			Inver./Ever.		

AREA	STRENGTH	ACTION	ROM

FUNCTIONAL INDEPENDENCE/BALANCE EVALUATION

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

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength – against gravity – full resistance.
4	Good strength – against gravity whh 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 activity muscle contraction.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

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

FUNCTIONAL INDEPENDENCE SCALE (For Balance/Mobility, Self Care/ADL Skills, IADL Skills)

GRADE	DESCRIPTION
7	Independent.
6	Modified independent – verbal cues, extra time.
5	Stand-by assist (SBA) – 100% effort w/supervision.
4	Minimal assist – 75% effort.
3	Moderate assist – 25-50% effort.
2	Maximum assist – 25% effort.
1	Dependent/unable to do task <25% effort.

Comments:

PHYSICAL THERAPY INTERVENTIONS

☐Establish HEP: ☐Given to Pt ☐In Chart ☐Gait Training ☐Orthotic Fitting/Fabrication/Training ☐Patient/Family/Caregiver Educatinn ☐Adaptive Equipment Training ☐Prosthetic Fitting/Fabrication/Training ☐Modalities: ☐Functinnal Mobility ☐Therapeutic Exercise ☐Balance ☐Neuro-Muscular Re-education ☐Other:

☐**DME Present:** _____ ☐**DME Needed:** _____

PHYSICAL THERAPY ORDERS

Frequency/Duration of PT Visits: _____

Assess/Perform/Instruct Pt/Cg:	A	P	I	Assess/Perform/Instruct Pt/Cg:	A	P	I
☐Posture Training/Exercises _____	☐	☐	☐	☐Gait Training _____	☐	☐	☐
☐L.E. Rom Exercises _____	☐	☐	☐	☐Joint Mobility Program _____	☐	☐	☐
☐L.E. Positioning & Body Alignment Exercises _____	☐	☐	☐	☐Home CPM Machine _____	☐	☐	☐
☐U.E. Rom Exercises _____	☐	☐	☐	☐Cast Care _____	☐	☐	☐
☐U.E. Positioning & Body Alignment Exercises _____	☐	☐	☐	☐Prosthetic Device _____	☐	☐	☐
☐Upper Body Muscle Strengthening Exercises _____	☐	☐	☐	☐Adaptive Device _____	☐	☐	☐
☐Lower Body Muscle Strengthening Exercises _____	☐	☐	☐	☐Wheelchair Measurement/Fittings _____	☐	☐	☐
☐Balance Exercises/Sitting _____	☐	☐	☐	☐Circulatory Checks as Applicable _____	☐	☐	☐
☐Balance Exercises/Standing _____	☐	☐	☐	☐Bed Mobility _____	☐	☐	☐
☐Endurance Improvement/Strength Exercises _____	☐	☐	☐	☐Transfer Techniques _____	☐	☐	☐

Additional Order (Specify): _____

GOALS/REHABILITATION POTENTIAL/DISCHARGE PLANS

☐The patient's safety will be enhanced throughout the home care service, as evidenced by:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient/caregiver will verbalize understanding of (disease process) and all aspects of associated care:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Gnal: Within: _____ weeks
☐The patient's home environment will be clean & safe, as evidenced by:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient's hygiene and personal care needs will be met this cert period with the assistance of the home health aide, as evidenced by:	Functional Short Term Gnal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient's ROM/Mobility will improve as evidenced by:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient's Muscle Strength will improve as evidenced by:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient's Balance will improve as evidenced by:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient's Gait will improve as evidenced by:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Gnal: Wlthin: _____ weeks
☐The patient's Ambulation will improve as evidenced by:	Fonctional Short Term Goal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient's Endurance will improve as evidenced by:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient's Pain will be controlled and managed at the patient's own comfort level as verbalized by the patient/caregiver within:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient will reach maximum functional potential, as evidenced by:	Functional Short Term Goal: Within: _____ weeks	Functional Long Term Goal: Within: _____ weeks
☐The patient will have psycho/social needs met, as evidenced by:	Functional Short Term Goal: Within: _____ weeks	Functiunal Long Term Goal: Within: _____ weeks

☐Other:

☐Rehabilitation potential:

Discharge Plans: ☐Patient to be discharged when skilled care no longer needed ☐Patient to be discharged to the care of: ☐Physician ☐Self ☐Caregiver

Other: _____

Skilled Services/Teaching provided this visit and Patient Response:

Assistance Required: ☐Maximum ☐Minimum ☐Moderate ☐Guarding ☐Other _____

DISTANCE AMBULATED: _____ **feet** with (DME): _____ **TUG Score=** _____

Patient Signature:	**Print Name:**	**Date:**
X		

Therapist Signature:	**Print Name:**	**Date:**	Time in ☐AM
X			Time out ☐PM

CHECK: ☐G0151-PT