SOUTHEAST HOMECARE

PHYSICAL THERAPY VISIT NOTE

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:

TYPE OF VISIT

Therapy Visit #________ ☐Revisit
☐Revisit and Supervisory Visit
☐Other (Specify):

VITAL SIGNS

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

Other:
Pulse: ☐Apical______ ☐Brachial______ ☐Radial______ ☐Regular ☐Irregular
Temp:__________ ☐Oral ☐Auxiliary
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 in home:

BEHAVIOR/MENTAL STATUS

☐Alert ☐Oriented ☐Anxious ☐Willing to Learn/Improve ☐Noncompliant
☐Other:

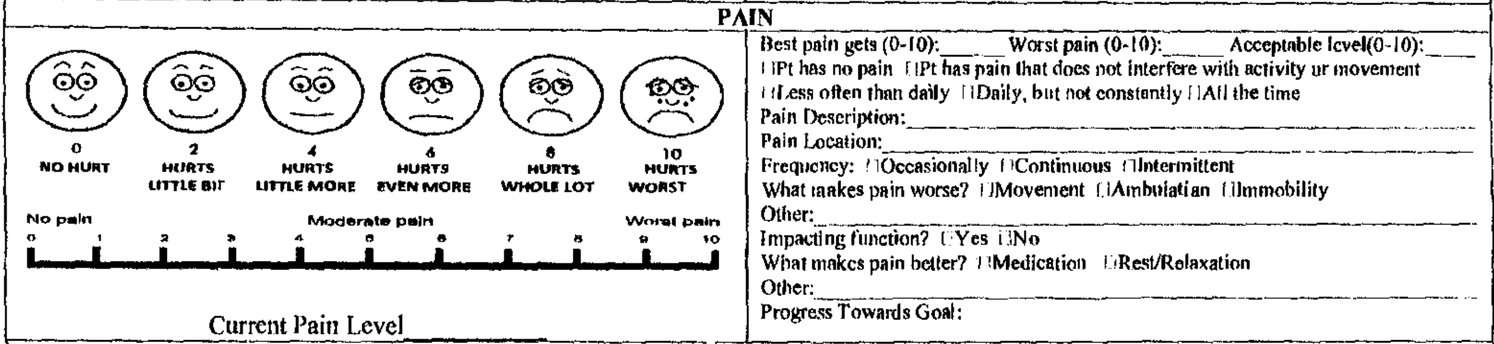
SKIN

Skin condition: ☐WNL ☐Warm/Dry

☐Edema Location:

☐Wound Location:

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:
Progress Towards Goal:

PHYSICAL THERAPY INTERVENTIONS

☐Establish HEP: ☐Given to Pt ☐In Chart ☐Gait Training ☐Orthotic Fitting/Fabrication/Training ☐Patient/Family/Caregiver Education ☐Adaptive Equipment Training ☐Prosthetic Fitting/Fabrication/Training ☐Modalities: ☐TENS ☐Functional Mobility ☐Therapeutic Exercise ☐Balance ☐Pulmonary PT ☐Neuro-Muscular Re-education
☐Other:
☐**DME Present:** ☐**DME Needed:**

INTERVENTIONS

SKILLED SERVICES PROVIDED (Treatment):

ASSISTANCE REQUIRED: ☐Maximum ☐Minimum ☐Moderate ☐Guarding ☐Other________

DISTANCE AMBULATED: ____________ **feet** with (DME): ____________ **TUG Score=**______
TEACHING:

PATIENT RESPONSE TO TEACHING:

Type of Teaching/Tool used:____________ Given to: ☐Patient ☐Caregiver ☐Both
☐Instruction ☐Pt/Cg. Verbalized Understanding ☐Pt/Cg. Return Demonstration ☐Home Therapy Program established: ☐Yes ☐No
Participation and follow through between visits is: ☐Adequate ☐Inadequate ☐Not Applicable ☐Other________
Medical Equipment/Adaptive Devices/Supplies used this visit:

SUPERVISORY VISIT ☐Scheduled ☐Unscheduled ☐PT Assistant Present on this visit? ☐Yes ☐No Following Plan of Care ☐Yes ☐No
Report changes in patient status? ☐Yes ☐No ☐N/A Patient satisfied with care? ☐Yes ☐No ☐Fall Precautions Maintained
☐Medication change since last visit? ☐No Yes, Specify: Changes made to ☐Plan of Care: ☐Yes ☐No

PROGRESS TOWARDS GOALS:

COORDINATION OF CARE:
Physician Contacted: ____________ Date/Time ________
Order Changes:
Plan for Next Visit:
Discharge Planning: ☐Patient to be discharged when skilled care no longer needed ☐ [Pa]tient to be discharged to the care of: ☐Physician ☐Self ☐Caregiver
☐Other:

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

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

CHECK ONE: ☐G0151-PT ☐G0157-PTA