PHYSICAL THERAPY EVALUATION

❑ Initial Evaluation
❑ Re-Evaluation (Type)________________

❑ Q5001: Hospice or Home Health Care provided in patient's home/residence
❑ Q5002: Hospice or Home Health Care provided in Assisted Living Facility
❑ Q5009: Hospice or Home Health Care provided in place not otherwise specified

DATE OF SERVICE ____/____/____
TIME IN________ TIME 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)________________

PERTINENT MEDICAL INFORMATION

Onset Date:____/____/____

Primary Diagnosis:________________

Medical Precautions/Limitations:
❑ Hypertension ❑ Cardiac ❑ Diabetes ❑ Respiratory ❑ Osteoporosis
❑ Fractures ❑ Cancer ❑ Infection ❑ Immunosuppressed ❑ Open Wound
❑ Other:________________

PAIN

Rating scale: 0 1 2 3 4 5 6 7 8 9 10 (0 = No pain, 5 = Mod pain, 10 = Worst pain) Current pain level:______ **(subjective reporting)**

Best pain gets:______ Worst pain gets:______ Acceptable level:______

Pain quality:________ (ache, sharp, dull, etc.) Pain location:________

Frequency: ❑ Occasionally ❑ Continuous ❑ Intermittent

What makes pain worse? ❑ Movement ❑ Ambulation ❑ Immobility
❑ Other:________________

Referral needed? ❑ Yes ❑ No Referred to:________________

Impacting function? ❑ Yes ❑ No (specify)________________

POC Goal Needed? ❑ **Yes** ❑ **No**

SOC DATE____/____/____
❑ G0151 ❑ G0159 Maintenance

PERTINENT BACKGROUND INFORMATION

Prior Level of Functioning:
ADLs: ❑ Independent ❑ Needed assist ❑ Total assist

In Home Mobility: ❑ Independent ❑ Assistive device ❑ Wheelchair/scooter ❑ Non-ambulatory

Community Mobility: ❑ Independent ❑ Assistive device ❑ Wheelchair/scooter ❑ Non-ambulatory

History of Falls:
Y/N If yes, date of last fall:____/____/____
Intervention in place? ❑ Yes ❑ No
If yes, specify:________________
Reported by: ❑ Patient ❑ Family ❑ Caregiver

Living Arrangements/Support System:
❑ Lives alone ❑ Caregiver available
❑ Limited support ❑ No caregiver available
Comment:________________

Environmental Barriers: ❑ Clutter ❑ Throw rugs
❑ Adaptive equipment needed: ❑ Yes ❑ No
(specify)________________

Other:________________

VITAL SIGNS

Blood Pressure: ❑ Sitting/lying R________ L________
❑ Standing R________ L________

Temperature:______ ❑ Oral ❑ Axillary ❑ Other:________

Pulse: ❑ Apical______ ❑ Brachial______ ❑ Radial______
Rhythm: ❑ Regular ❑ Irregular

Respirations:______ ❑ Regular ❑ Irregular

O_2 @ ______LPM via: ❑ Cannula ❑ Mask ❑ Trach

O_2 saturation _____%: ❑ At rest ❑ With activity

Impacting function? ❑ Yes ❑ No (specify)________________

POC Goal Needed? ❑ **Yes** ❑ **No**

BEHAVIOR/MENTAL STATUS

❑ Alert ❑ Oriented ❑ Cooperative ❑ Confused
❑ Memory deficits: ❑ Short term ❑ Long term ❑ Impaired judgment
❑ Other:________________

Impacting function? ❑ Yes ❑ No (specify)________________

POC Goal Needed? ❑ **Yes** ❑ **No**

GAIT

Assistance: ❑ Independant ❑ SBA ❑ CGA ❑ Min. assist ❑ Mod. assist ❑ Max. assist ❑ Dependent

Adaptive Device: ❑ No device ❑ Crutches ❑ FWW ❑ 4WW ❑ Hemi Walker ❑ SBQC ❑ LBQC ❑ SPC ❑ Other:________

Surfaces within Functional Area: ❑ Level ❑ Uneven ❑ Stairs (# if known_____) Distance/Time:________/________

Functional Distance Needed for: ❑ Toileting: _____ ft ❑ Bed: _____ ft ❑ Chair: _____ ft

Weight Bearing Status: ❑ FWB ❑ WBAT ❑ PWB ❑ TDWB ❑ NWB

Gait Quality/Deviations/Postures:________________

Impacting function? ❑ Yes ❑ No (specify)________________

POC Goal Needed? ❑ **Yes** ❑ **No**

Comments:________________

PATIENT NAME – Last, First, Middle Initial	ID#

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PHYSICAL THERAPY EVALUATION (Cont'd.)

MUSCLE STRENGTH/FUNCTIONAL ROM EVAL

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

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance.
4	Good strength - against gravity with 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 active 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/BALANCE EVAL

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

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% afford.
1	Dependant/unable to do task <25% afford.

Comments: ______________________________

____

____

SUMMARY

❑ Education/Instruction provided: ❑ Safety ❑ Exercise ❑ Other (Describe)______________________________

❑ PT evaluation only. ❑ No further indications for PT services

Was a standardized/validated assessment used? ❑ Yes ❑ No If yes (specify assessment):______________________________

Results:______________________________

❑ Orders for PT evaluation only. ❑ Needs additional PT services. See PT Care Plan/485 for recommendations.

❑ Need to obtain orders: (specify)______________________________

❑ Orders for PT services with specific treatments, frequency and duration. See PT Care Plan/485.

Other disciplines providing care: ❑ SN ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ Other:______________________________

❑ Equipment recommendations: (specify)______________________________

❑ There are no changes to the POC based upon this assessment, at this time.

Was a need identified or reported during this assessment in any of the following areas that requires a referral? ❑ Nutrition ❑ Medications ❑ Pain ❑ Injuries/Wounds ❑ Psychosocial concerns ❑ Self care skills ❑ IADLs ❑ Safety issues ❑ Other:______________________________

❑ Yes ❑ No If Yes: (specify)______________________________

❑ Referral recommendations: (specify)______________________________

Comments:______________________________

____

DISCHARGE DISCUSSED WITH: ❑ Patient ❑ Family/Caregiver ❑ Care Manager ❑ Physician ❑ Other:______________________________

BILLABLE SUPPLIES: ❑ N/A ❑ Yes (specify)______________________________

CARE COORDINATION: ❑ Physician ❑ Nursing ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ Othar______________________________

APPROXIMATE NEXT VISIT DATE: _____/_____/_____

PLAN FOR VISIT:______________________________

____

____

____

SIGNATURES/DATES

Complete TIME DUT (on previous page) prior to signing below.

X______________________________ _____/_____/_____

Patient/Caregiver (if applicable) *Date*

______________________________ _____/_____/_____

Therapist (signature/title) *Date*