❑ 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

PHYSICAL THERAPY REVISIT NOTE

DATE OF SERVICE _____/_____/_____
TIME IN_____ **TIME OUT**_____

VITAL SIGNS: Temp:_____ Pulse:_____ Regular / Irregular Resp.:_____ B/P:_____
Using O_2 at _____LPM via:_____
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)
Pain quality:_____ (ache, sharp, etc.) Pain location:_____ Frequency:_____

TYPE OF VISIT:
❑ Revisit and Supervisory Visit
SOC DATE_____/_____/_____
❑ G0151 PT ❑ G0157 PTA

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)_____

Safety Issues:
❑ Obstructed pathways ❑ Home environment
❑ Stairs ❑ Unsteady gait
❑ Verbal cues required
❑ Equipment in poor condition ❑ Bathroom
❑ Commode
❑ Others (specify):_____

Treatment Diagnosis/Problem Area(s):
❑ Coordination deficits (Fine/Gross)
❑ Lower body weakness/limited ROM
❑ Increased falls
❑ Impaired functional ambulation
❑ Impaired gait quality, posture, deviation
❑ Decreased independence with functional transfers
❑ Impaired balance, loss of balance
❑ Limited functional mobility (w/c, ambulation, etc.)
❑ Other:_____

Referral Made: ❑ Yes ❑ No If Yes (specify)_____

PHYSICAL THERAPY INTERVENTIONS

❑ Establish HEP:
❑ Given to Pt ❑ In Chart
❑ Patient/Family/Caregiver Education
❑ Adaptive Equipment Training
❑ Therapeutic Exercise
❑ Neuro-Muscular Re-education
❑ Gait Training
❑ Balance
❑ Modalities: ❑ TENS
❑ Ultrasound ❑ E-stim
❑ Heat ❑ Ice
❑ Pulmonary PT
❑ Orthotic Fitting/Fabrication/Training
❑ Prosthetic Fitting/Fabrication/Training
❑ Functional Mobility
❑ Other:_____

GOALS/OUTCOMES: Patient/Therapist identified functional based goals (areas identified in evaluation)

Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards independence:
Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards independence:
Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards independence:
Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards independence:

Adaptive Equipment Needs identified and/or Trained on:	Patient/Caregiver/Family Response:

Demonstrates Rehab Potential as: ❑ Poor ❑ Fair ❑ Good ❑ Excellent
Patient demonstrates potential for continued gains towards a greater level of functional independence and will benefit from continued Physical Therapy Services to address deficit areas impacting his/her function. Please see Physical Therapy Evaluation and Plan of Care for further detailed information regarding current functional level and areas of focus.

CARE PLAN: ❑ Reviewed/Revised with Patient/Caregiver/Family
Revised ❑ Yes ❑ No (specify):_____
APPROXIMATE NEXT VISIT DATE:_____/_____/_____
PLAN FOR NEXT VISIT:_____
DISCHARGE PLAN DISCUSSED WITH: ❑ Patient/Family
❑ Care Manager ❑ Physician ❑ Other:_____
BILLABLE SUPPLIES USED? ❑ N/A ❑ Yes (specify):_____
CARE COORDINATION DISCUSSED WITH: ❑ Physician ❑ Nursing
❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ Other:_____

SUPERVISORY VISIT (Complete if applicable)

❑ PT Assistant ❑ Aide / ❑ Present ❑ Not present
Supervisory Visit: ❑ Scheduled ❑ Unscheduled
Observation of:_____
Teaching/Training of:_____
Next Scheduled Supervisory Visit:_____
Care plan reviewed/revised with assistant/aide during this visit:
❑ Yes ❑ No If yes (specify):_____
If PT assistant/aide not present, specify data he/she was contacted regarding updated care plan:_____/_____/_____

Comments:_____

SIGNATURES/DATES

X_____ _____/_____/_____
Patient/Caregiver (if applicable) *Date*

Complete **TIME OUT** (above) prior to signing below.
_____ _____/_____/_____
Therapist (signature/title) *Date*

PATIENT NAME – Last, First, Middle Initial | **ID#**