ULTRA
HEALTH CARE

☐ 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 (No Pain / Mod Pain / Worst Pain) Current Pain Level:__________ (subjective reporting)
Pain Quality:______________ (ACHE, SHARP, ETC.) **Pain Location:**______________ **Frequency:**______________
Complete Cocare/ Ultra Health Pain Assessment # per agency policy

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
☐ Unable to safely leave home unassisted
☐ Dependent upon adaptive device(s)
☐ Other (specify)________________________________
☐ Confusion, unable to go out of home alone
☐ Severe SOB, SOB upon exertion
☐ Medical restrictions

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:____________________

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

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:____________________

GOAL/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 physicalTherapy 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.

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 date he/she was contacted regarding updated care plan: ______/_______/_______

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:________________

COMMENTS: ____________________
____
____
____

SIGNATURES/DATES

X____________________ ______/______/______
Patient/caregiver (If Applicable) *Date*

____________________ ______/______/______
Therapist (Signature/title) *Date*

PATIENT NAME - Last, First, Middle Initial	ID#