Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

PT Visit

Patient Name: Test Patient **MR:** XXXX **Visit Date:** 5/21/2018

Episode Period: 05/08/2018 - 07/06/2018 **Time In:** 01:30 PM **Time Out:** 02:30 PM

Associated Mileage: **Surcharge:** **Physician:** Test Physician M.D.

Homebound Reason

☐ N/A

☒ Requires considerable and taxing effort.
☒ Needs assist with transfer.
☒ Needs assist leaving the home.
☐ Severe SOB upon exertion.
☐ Medical restriction.
☒ Needs assist with ambulation.
☒ Unable to be up for long period.
☒ Unsafe to go out of home alone.

Functional Limitations

☐ N/A

☒ ROM/Strength.
☒ Safety Techniques.
☒ Balance/Gait.
☒ Transfer.
☐ Coordination.
☐ Pain.
☐ W/C Mobility.
☐ Bed Mobility.
☒ Increased fall risk.

Vital Signs

☐ N/A

SBP	DBP	HR (Radial)	Resp	Temp	Weight	O2 Sat
126	74	80	16	97.4		

Supervisory Visit

☒ N/A

Subjective

☐ N/A

PATIENT DEMONSTRATES NO SIGNS /SYMPTOMS OF PAIN,
PATIENT FOUND RESTING IN R SIDE LYING POSITION

Objective

☐ N/A

☐ Therapeutic Exercises

ROM to _____ x _____ reps
Active to _____ x _____ reps
Active/Assistive to _____ x _____ reps
Resistive, Manual, to _____ x _____ reps
Resistive, w/Weights, to _____ x _____ reps
Stretching to _____ x _____ reps

Comment

1. SUPINE - BILATERAL HIP/KNEE EXTENSION, 2 MIN X 3
2. LUMBAR ROTATION IN HOOK LYING 20 X 2

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician PT 5/21/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

PT Visit

Patient Name: **MR:** XXXX **Visit Date:** 5/21/2018

Episode Period: 05/08/2018 - 07/06/2018 **Time In:** 01:30 PM **Time Out:**

Associated Mileage: **Surcharge:** **Physician:X)** Test Physician M.D.

Objective

3. LEFT SIDE LYING WITH LEFT UE JOINT MOBILITY/WRIST/HAND
4. SIT TO STAND REPETITIONS. 7 X 1
5. STATIC STAND - 15 SECONDS X 5

Functional Mobility Key

I = Independent	S = Supervision	VC = Verbal Cue	CGA = Contact Guard Assist
Min A = 25% Assist	Mod A = 50% Assist	Max A = 75% Assist	Total = 100% Assist

Bed Mobility Training

☐ N/A

Rolling	Min A = 25% Assist x 2 reps
Sup-Sit	Min A = 25% Assist x 2 reps
Scooting Toward	_____ x 2 reps
Sit to Stand	_____ x 7 reps

Comment

SUPINE TO SIT WITH HEAD OF BED RAISED
SIT TO STAND AT EDGE OF BED AND FROM W/C

Transfer Training

☐ N/A

Transfer Training	X 6 reps
Assistive Device	None
Bed — Chair	Mod A = 50% Assist
Chair — Toilet	Not Tested
Chair — Car	Not Tested

Sitting Balance Activities	Static:G = Maintain static sitting/standing with moderate challenges from all directions.	Dynamic:
Standing Balance Activities	Static:F- = Maintain static sitting/standing balance with CG assist.	Dynamic:P+ = Maintain dynamic sitting/standing balance through minimal excursions of active trunk movement with minimal assist.

Comments

DYNAMIC SITTING BALANCE = GOOD MINUS

Gait Training

☐ N/A

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician PT 5/21/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

PT Visit

Patient Name: Test Patient 1581 **MR:** **Visit Date:**

Episode Period: 05/08/2018 - 07/06/2018 **Time In:** 01:30 PM **Time Out:** 2:30 PM

Associated Mileage: **Surcharge:** **Physician:**

Gait Training

Ambulation	Distance5 STEPSft x3 reps	**Assistive Device**	None
Assistance	Mod A = 50% Assist	**Gait Quality/Deviation**	
Stairs	# of Steps_____	☐ Rail 1	☐ Rail 2
Assistive Device		**Assistance**	
Gait Quality/Deviation			

Teaching

☐ N/A

☒ Patient ☐ Caregiver ☒ HEP ☒ Safe Transfer ☒ Safe Gait

Other

1. TRANSFER TRAINING - PHYSICAL SUPPORT FOR LE /TRUNK POSITIONING DURING SET UP, MULTIPLE ATTEMPTS TO ENGAGE PATIENT WITH TRANSFER POLE, UNSUCCESSFUL/ INCONSISTENT. PHYSICAL SUPPORT/ TACTILE CUES TO PELVIS /TRUNK, VERBAL CUES FOR POSTURE, LE EXTENSION, TACTILE CUES FOR LATERAL WT SHIFT TO FACILITATE LE MOBILITY DURING PIVOT.
2. STANDING BALANCE TRAINING - LATERAL WT SHIFT, STATIC STANDING WITHOUT ASSISTIVE DEVICE.
3. GAIT TRAINING - PHYSICAL SUPPORT TO TRUNK PELVIS, L HIP /KNEE DURING STANCE PHASE, LATERAL WT SHIFT TO FACILITATE BILATERAL STEP.
4. BED MOBILITY TRAINING - TACTILE CUES TO LE'S FOR MANAGEMENT, VERBAL CUES TO INITIATE. TACTILE CUES TO TRUNK DURING TRANSITION, TACTILE CUES TO LATERAL PELVIS TO INITIATE SIDE LYING TO SIT TRANSITION.

Pain

☐ N/A

Pain level prior to therapy	0=No Pain	**Pain level after therapy**	0
Location		**Relieved by**	

Other Comments

Assessment

☒ N/A

Plan

☐ N/A

Continue Prescribed Plan	TRANSFER TRAINING, BALANCE TRAINING, THEREX, BED MOBILITY,
Change Prescribed Plan	
Plan Discharge	
Comments	

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician PT 5/21/2018

Arias Home Health
4811 Chippendale Dr.#201
Sacramento, CA 95841
Phone: (916) 913-1134 | Fax: (916) 993-9122

PT Visit

Patient Name: Test Patient **MR:** XXXX **Visit Date:** 5/21/2018

Episode Period: 05/08/2018 - 07/06/2018 **Time In:** 01:30 PM **Time Out:** 02:30 PM

Associated Mileage: **Surcharge:** **Physician:** Test Physician M.D.

Plan

Narrative

☐ N/A

DISCUSSION WITH NURSING SUPERVISOR REGARDING DIFFICULTY INCORPORATING TRANSFER POLE . UNABLE TO ENGAGE PATIENT WITH ASSISTIVE DEVICE.

REQUESTED FEED BACK FROM STAFF REGARDING THEIR EXPERIENCES WITH TRANSFER POLE AT THIS TIME DISCUSSED CONCERNS THAT TRANSFER POLE MAY BE MAKNG IT DIFFICULT FOR STAFF TO POSITION THEMSELVES PROPERLY DURING TRANSFER SET UP.

Progress made towards goals

☒ N/A

Skilled treatment provided this visit

☐ N/A

☒ Therapeutic exercise	☒ Bed Mobility Training	☒ Transfer Training
☒ Balance Training	☒ Gait Training	☐ Neuromuscular re-education
☒ Functional mobility training	☒ Teach safe and effective use of adaptive/assist device	☐ Teach safe stair climbing skills
☒ Teach fall prevention/safety	☒ Establish/upgrade home exercise program	☐ Pt/caregiver education/training
☐ Proprioceptive training	☐ Postural control training	☐ Teach energy conservation techniques
☐ Relaxation technique	☐ Teach safe and effective breathing technique	☐ Teach hip precaution

☐ Electrical stimulation **Body Parts:** _____ **duration:** _____

☐ Ultrasound **Body Parts:** _____ **duration:** _____

☐ TENS **Body Parts:** _____ **duration:** _____

☐ Prosthetic training ☐ Pulse oximetry PRN

Other

Clinician Signature: **Date:**

Electronically Signed by: Test Clinician PT 5/21/2018