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PHYSICAL THERAPY EVALUATION

SOC Date: 05/22/2018 Other Disciplines providing care: ☑ SN ☑ OT ☐ ST ☐ MSW ☐ Aide

HOMEBOUND REASON

☐ Needs assistance for all activities ☐ Confusion, unable to go out of home alone ☑ Dependent upon adaptive device(s)
☐ Severe SOB, SOB upon exertion ☑ Unable to safely leave home unassisted ☐ Medical restrictions ☑ Residual weakness
☑ Requires assistance to ambulate ☐ Other:

PERTINENT BACKGROUND INFORMATION

PT ORDERS: ☑ Evaluation ☑ Therapeutic Exercise ☑ Transfer Training ☑ Home Program Instruction ☑ Gait Training ☐ Chest Pt.
☐ Ultrasound ☐ Electrotherapy ☐ Prosthetic Training ☐ Muscle Re-education ☐ Others:

TREATMENT / DIAGNOSIS / PROBLEM:

Generalized Muscle Weakness.

REASON FOR EVALUATION

Decline of function.

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MEDICAL HISTORY ☑ Hypertension ☑ Cardiac ☐ Diabetes ☐ Respiratory ☐ Osteoporosis ☐ Cancer ☑ Arthritis
☐ Fractures ☐ Immunosuppressed
☐ Other (specify):

PRIOR LEVEL OF FUNCTION

ADLs: ☐ Independent ☑ Level of assistance ☐ Unable Equipment Used:
Other: Min a.

IN-HOME MOBILITY (gait or wheelchair/scooter): ☐ Independent ☑ Level of Assist MI. ☐ Unable
Equipment Used: ☐ No AD ☐ Cane/QC ☑ Walker/RW ☑ W/C/Scooter Other:

TRANSFER MOBILITY: ☐ Independent ☑ Level of Assist MI. ☑ Unable
Equipment Used: ☐ No AD ☐ Cane/QC ☑ Walker/RW ☐ W/C/Scooter Other:

COMMUNITY MOBILITY (gait or wheelchair/scooter): ☐ Independent ☐ Level of Assist ☑ Unable
Equipment Used: ☐ No AD ☐ Cane/QC ☐ Walker/RW ☐ W/C/Scooter Other:

LIVING SITUATION

☐ Capable ☐ Able ☑ Willing caregiver available ☐ ALF ☐ Limited caregiver support (ability/willingness) ☐ No caregiver available

HOME SAFETY BARRIERS: ☑ None ☐ Clutter ☐ Throw rugs ☐ Bath bench/equipment ☐ Needs grab bar ☐ Needs railings
☐ Steps (number/condition) ☐ Other (specify):

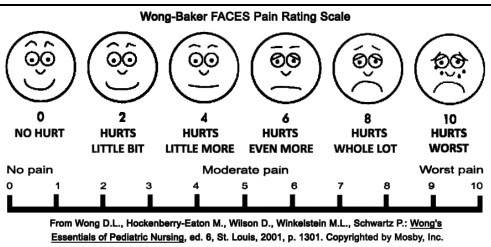
BEHAVIOR / MENTAL STATUS

☑ Alert ☑ Orient ☐ x 1 ☐ x 2 ☑ x 3 ☑ Cooperative ☐ Confused ☑ Memory deficits ☐ Impaired judgment
☐ Other (specify):

VITAL SIGNS / CURRENT STATUS

Blood Pressure: 134/80 mmHg
Pulse: 95 bpm
Respirations: 18 cpm
Skin Condition: Good.
Edema: Mild.
Vision: Daytime glasses due to glaucoma.
Sensation: Decreased on R lower leg.
Communication: Good.
Hearing: Impaired.
Posture: Impaired.
Activity Tolerance: Decreased.
Muscle Tone: Normal.
Orthotic/Prosthetic devices: None.

PAIN



Pain Intensity: 4
☐ None
LOCATION: Medial R knee.
FREQUENCY: ☐ Occasional ☑ Intermittent ☐ Continuous
Aggravating/Relieving Factors:
Nightime.

GAIT

ASSISTANCE: ☐ Independent ☑ SBA ☐ Contact Guard ☐ Minimum Assist ☐ Moderate Assist ☐ Maximum Assist ☐ Unable
SURFACES: ☑ Level ☐ Uneven ☐ Stairs (number/condition) Distance/Time: 25 ft.
WEIGHT BEARING STATUS: ☑ FWB ☐ WBAT ☐ PWB ☐ TTWB ☐ NWB
ASSISTIVE DEVICE(S): ☐ Cane ☐ Quad Cane ☐ Crutches ☐ Hemi Walker ☐ Walker ☑ Wheeled Walker
☐ Other (specify):
QUALITY/DEVIATIONS/POSTURES:

Patient Name: Test Patient **MR#:** #0000000000

5/24/2018 01:45 PM – 02:30 PM | Test Clinician | Visit Type: PT Evaluation(G0159) | Insurance: Medicare | Episode Period: 05/22/2018 – 07/
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MUSCLE STRENGTH / FUNCTIONAL ROM EVALUATION

AREA	STRENGTH Right	STRENGTH Left	ACTION	AROM Right	AROM Left
UPPER EXTREMITIES DEFAULT STRENGTH / ROM ☐					
					Refer to OT
Shoulder	3 / 3	3 / 3	Flex/Extend	3 / 3	3 / 3
	3 / 3	3 / 3	Abd./Add.	3 / 3	3 / 3
	3 / 3	3 / 3	Int. Rot./Ext. Rot.	3 / 3	3 / 3
Elbow	3 / 3	3 / 3	Flex/Extend	3 / 3	3 / 3
Forearm	3 / 3	3 / 3	Sup./Pron.	3 / 3	3 / 3
Wrist	3 / 3	3 / 3	Flex/Extend	3 / 3	3 / 3
Fingers	3 / 3	3 / 3	Flex/Extend	3 / 3	3 / 3
LOWER EXTREMITIES DEFAULT STRENGTH / ROM ☐					
					Refer to PT
Hip	3 / 3	3 / 3	Flex/Extend	3 / 3	3 / 3
	3 / 3	3 / 3	Abd./Add.	3 / 3	3 / 3
	3 / 3	3 / 3	Int. Rot./Ext. Rot.	3 / 3	3 / 3
Knee	3 / 3	3 / 3	Flex/Extend	3 / 3	3 / 3
Ankle	3 / 3	3 / 3	Plant./Dors.	3 / 3	3 / 3
Foot	3 / 3	3 / 3	Inver./Ever.	3 / 3	3 / 3

SPINE

AREA	STRENGTH	ACTION	ROM

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal function 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 (AROM) SCALE

GRADE	DESCRIPTION
5	100% active functional motion
4	75% active functional motion
3	50% active functional motion
2	25% active functional motion
1	Less than 25%

FUNCTIONAL INDEPENDENCE / BALANCE EVALUATION

TASKS	ASSIST SCORE	ASSISTIVE DEVICE/COMMENTS
BED MOBILITY		
Roll/Turn	6	
Sit/Supine	6	
Scoot/Bridge	6	...more ☐
TRANSFERS		
Sit/Stand	5	
Bed/Wheelchair	5	
Toilet	5	
Floor	3	
Auto		...more ☐
WHEELCHAIR SKILLS		
Propulsion	N/A	
Pressure Reliefs	N/A	
Foot Rests	N/A	
Locks	N/A	...more ☐

FUNCTIONAL INDEPENDENCE SCALE

GRADE	DESCRIPTION
6	Independent - physically able and independent
5	Supervision and/or Verbal Cues - 100% patient effort
4	Contact Guard - 100% patient effort
3	Minimum Assist (Min A) - 75% patient/client effort
2	Moderate Assist (Mod A) - 50% patient effort
1	Maximum Assist (Max A) - 25% - 50% patient/client effort
0	Totally Dependent - total care/support

TASKS	ASSIST SCORE	ASSISTIVE DEVICE/COMMENTS
BALANCE		
Static Sitting	Norma	
Dynamic Sitting	Good	
Static Standing	Fair	
Dynamic Standing	Fair	...more ☐

SAFETY ISSUES

- ☐ Obstructive pathways
- ☐ Home environment
- ☐ Stairs
- ☑ Unsteady gait
- ☑ Other (specify): TUG test 14.57 secs.
- ☐ Equipment in poor condition
- ☐ Bathroom
- ☐ Impaired judgment/safety
- ☑ Verbal cues required

PHYSICAL THERAPY CARE PLAN / INTERVENTIONS

- ☑ Evaluation
- ☑ Establish rehab. program
- ☑ Establish home exercise program
- ☑ Patient/Family education
- ☑ Therapeutic/Isometric/Isotonic Exercises
- ☑ Muscle Strengthening
- ☐ Passive/Active/Resistive exercises
- ☐ Stretching exercises
- ☑ Transfer Training
- ☑ Balance Training/Activities
- ☐ Pulse Oximetry
- ☐ Other (specify):
- ☑ Gait Training
- ☐ Home exercise program upgrade
- ☐ Pulmonary Physical Therapy
- ☐ Disease Process and Management
- ☑ Energy Conservation Techniques
- ☐ Prosthetic Training
- ☐ Preprosthetic Training
- ☐ Management and Evaluation of Care Plan
- ☐ Muscle/Neuro Re-education
- ☑ Breathing/CP Conditioning Exercises
- ☐ Pain Management
- ☐ CPM (specify)
- ☐ Functionality Mobility Training
- ☑ Teach safe/effective use of adaptive/ assistive device
- ☐ Teach safe stair climbing skills
- ☐ Teach bed mobility skills
- ☐ Teach hip safety precautions
- ☑ Falls Prevention
- ☑ Body Mechanics/Posture Training

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Monitor Vital Signs:

- ☐ Pulse
- ☐ Blood Pressure
- ☐ Respirations

PROVIDE:

- ☐ U.S. to _____ at _____ warts/cm2 x _____ minutes.
- ☐ EMS to _____ x _____ minutes.
- ☐ Heat/Cold to _____ x _____ minutes.
- ☐ Therapeutic massage to _____ x _____ minutes.
- ☐ Joint Mobilization

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GOALS

☑ Refer to physician order goals

REHAB POTENTIAL

☐ Poor ☐ Fair ☑ Good ☐ Other:

ADDITIONAL INFORMATION

1. Patient will improve TUG test to <11 secs in 4 weeks.
2. Patient will ambulate safely and independently with 4WW on B even and uneven surfaces with MI up to 150 ft in 4 weeks.
3. Patient to improve Berg Balance Score to 38/56 in 4 weeks.
4. Patient will imrove B LE to 4+/5 in 2 weeks.
5. Patient will improve safety awareness in 2 weeks.
6. Patient will increased independence with HEP in 2weeks.

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SUMMARY

INSTRUCTIONS PROVIDED: ☑ Safety ☐ Exercise ☑ Other (describe): Edema management.

Equipment needed (describe):

DISCHARGE DISCUSSED WITH: ☑ Patient/Family ☐ Care Manager ☐ Physician ☐ Other (specify):

CARE COORDINATION: ☑ None ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ PTA ☐ COTA ☐ Aide ☐ Case Manager ☐ Other (specify):

Approximate Next Visit Date:

05/26/18

PLAN FOR NEXT VISIT:

Initiate thera ex, safety education, standing balane, transfers and ambulation training.

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THERAPIST PRINTED NAME: Test Clinician

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