APPLIED HEALTHCARE SOLUTIONS, INC.
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PHYSICAL THERAPY VISIT

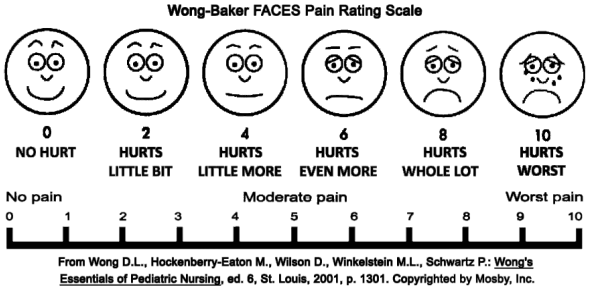
TREATMENT / DIAGNOSIS / PROBLEM:
GENERALIZED MISCLE WEAKNESS.

HOMEBOUND REASON

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

VITAL SIGNS

Temperature: ☑ N/A ☐ Oral ☐ Axillary ☐ Temporal ☐ Tympanic
Pulse: ☐ Apical ☑ Radial 87 Regular
Respirations: 17 Regular At Rest
Blood Pressure: 122 / 72 ☑ Right ☐ Left
Weight: ☑ N/A
PAIN: ☑ None ☐ Same ☐ Improved ☐ Worse
Location(s):
Frequency: ☐ Constant ☐ Intermittent ☐ Occasional Intensity (0-10) 0
Relief Measures:



INTERVENTIONS

Facilitated ambulation with 4WW on even and ramp with rest breaks and DBEs. Addressed LE strengthening in sitting towards knee ext and hip fle x10 reps x 3 sets each with rest breaks of at least 2 mins. Instructed patient o elevate legs after PT treatment to decreased LE edema.

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ASSESSMENT / PROGRESS TOWARDS GOALS

Patient tolerated all PT management given without adverse effects noted.

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SAFETY ISSUES

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

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SUPERVISORY VISIT (Complete if applicable)

Supervisory Visit: ☐ Scheduled ☐ Unscheduled ☐ PT Assistant ☐ Aide ☐ Present ☐ Not Present ☐ N/A
Observation of:
Teaching/Training of:
Patient/Family Feedback on Services/Care (specify):
Care Plan updated? ☐ No ☐ Yes, specify

SUMMARY

INSTRUCTIONS PROVIDED: ☑ Safety ☑ Exercise ☐ Other (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: 06/11/18

PLAN FOR NEXT VISIT: ☑ Continue with patient plan of care
THERAPIST PRINTED NAME: Test Clinician

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

6/6/2018 09:00 AM - 09:45 AM | Test Clinician | Visit Type: PT Visit(G0151) | Insurance: Medicare | Episode Period: 05/22/2018 - (
Electronically signed by Test Clinician on 06/06/2018