PHYSICAL THERAPY INITIAL EVALUATION/REEVALUATION/PHYSICIAN'S CERTIFICATION/DISHARGE SUMMARY Initial Eval 3 30th Day 111Th 1 12Th 113Th D/C

PT

Patient Name: _____ Date: _____Time In: _____ Time Out:_____

Diagnosis: _____

Pt. Signature: _____ Physician: _____

Medical HX: Resting Vitals: Blood Pressure: Heart Rate: (R/IR) Respiration:

▫ Heart Disease	▫ Hernia	▫ PVD	▫ OA	▫ CVA	▫ COPD
▫ HTN/hypertension	▫ Bladder & Bowel	▫ CA/tumor	▫ RA	▫ Dementia	▫ Respiratory SX
▫ Pacemaker	▫ DM	▫ Spinal SX	▫ THR/TKR	▫ Alzheimer's	▫ Parkinson's
▫ Bypass	▫ DM	▫FX			

LIVING ARRANGEMENTS: __alone __with family/friend __paid help __24hr care __someone is home during day to assist pt. __weekly assist __pt. provides primary care for another person __someone is home evenings &night to assist pt. __monthly asisist

HOME ACCESIBILITY: **DWELLING:** __house __apartment __trailer __stairs __elevator __steps_____ __rail __ramp

SAFETY ISSUES:_____

Architectural Barriers:	▫ Narrow Doorways	▫ Threshold Height	▫ Throw Rugs	▫ Electrical Cords
	▫ Tub/shower combo	▫ Glass Shower Doors	▫ Clutter	▫ Other:

AVAILBALE DME/AE:	▫ Gait Belt	▫ BSC/ elevated commode	▫ Reacher	▫ Oxygen
	▫ SW/RW.SC/QC	▫ Tub Transfer Bench	▫ Sock Aide	▫ Hospital Bed
	▫ Prosthesis	▫ Hand Held Shower Head	▫ Dsg Stick	▫ Rails Up
	▫ Manual/ Electric W/C	▫ Grab Bars	▫ Shower Brush	

PRIOR LEVEL OF FUNCTION**:** I=Independent , MI=Modified Independent, S=Supervision, CGA=Contact Guard, Min=Minimal (25%) Mod=Moderate (50%), Max=Maximum (75%), D=Dependent (100%)

Transfers: Bed Mobility: Toileting: ADL's: Household Ambulation Steps/ Stairs Community Ambulation

Comments_____

Vision	Hearing	Speech	Understanding	Orientation	Follow Directions	Behavior/Mood	Memory	Safety
▫ Adequate ▫ Impaired ▫ Glasses	▫ Adequate ▫ Impaired ▫ Aids	▫ Adequate ▫ Impaired ▫ Aids	▫ Usually ▫ Sometimes ▫ Rarely ▫ Never	▫ Person ▫ Place ▫ Time ▫ Situation	▫ No ▫ Yes-with/ wo ▫ cues ▫ Demo	▫ Cooperative ▫ Agitated ▫ Labile ▫ Lethargic	▫ Adequate ▫ Impaired	▫ Adequate ▫ Impaired

Functional Grading (appropriate safe level, not what is available): I-Independent, MI-Modified Independent (holds onto walls w/assistive devices), S=Supervision, CGA=Contact Guard, Min-Minimal (25%) Mod=Moderate (50%), Max=Maximum (75%), D=Dependent (100%), NT=Not tested, 5 Normal, 4 Good, 3 Fair, 2 Poor, 1 Trace, 0 Zero, WFL-Within Functional Limits, ↓=Diminish, ↑=Increase, U=Unable

	Status		Status		Status
SENSTATION		**TRANSFERS**		**BALANCE**	
PROPRICOCEPTION		Supine ↔ Sit		Static Sit	
EDEMA		Sit↔ Stand		Dynamic Sit	
CIRCULATION		Bed↔ W/C		Static Stand w/AD	
EATING		BSC/Commode		Dynamic Stand w/AD	
GROOMING		Bath		FUNCTIONAL TESTS	Choose 1 or more
TOILETING		Car		Single Leg Stance	__<than 5.7sec=Fall risk
DRESS		GAIT ANALYSIS		Functional Reach Test (in)	__<11.8in =Fall risk
BATH tub/shower/bath		▫ Independent: Safely ambulates (I) on level, unlevel ground stairs, and community distances:		Timed Sit to Stand 30 (sec)	__<than 13=fall risk
MEAL PREP				Timed Up & Go 10 ft (sec)	>7.2=Fall Risk
HOUSECLEANING		▫ Modified I Safe w/ assistive device on level $ unlevel ground, stairs, and community distances		Tinetti Assessment (28 pt)	≤24 =abnormal
				Gait & Balance Test score	<19 =Fall Risk
BED MOBILITY		Safest level of Assisted Gait with device_____			
Rolling R/L		▫ Supervision ▫SBA/Verbal Cues ▫ CGA		POSTURE	
Scooting/Bridging		▫ Min Assust ▫ Moderate Assist ▫ Max Assist		Cervical	
W/C Management		▫ Distance X_____feet / minutes X____rest stops		Thoracic	
Propel in straight line		_____		Lumbar	
In/out bedroom		_____		Leg Length	
Manipulate leg rest		▫↓Stride ▫↓ Cadence ▫↓ Heel Clearance		PAIN (0-10)	
Lock/unlock brakes		▫ Toe Drag ▫ Ataxia ▫ Hemiplegic R/L		Site	
Reposition Self		▫ Antalgic Gait ▫ Festination		Site	

PHYSICAL THERAPY EVALUATION

Patient Name: _____

Manual Muscle Test: 5=Normal, 4=Good, 3=Fair, 2=Poor, 1=Trace, 0=Zero
WFL=within functional limits WNL=normal "Synergistic Pattern
Range of Motion Test=Active ROM "PROM=Passive ROM

STRENGTH		Hand Dominance	ROM	
R	L		R	L
		Cervical		
		Shoulder Flex/Ext		
		Shoulder Abd/Add		
		Shoulder IR/ER		
		Elbow Sup/Pron		
		Wrist RD/UD		
		Hand Grip		
		Finger Flex/Ext		
		Finger Abd/Add		
		Hip Flex/Ext		
		Hip Abd/ Add		
		Hip IR/Er		
		Knee Flex/Ext		
		Ankle PF/DF		
		Ankle Inver/Ever		
		Trunk Felx/Ext		

Precautions: ▫
▫ Universal ▫ Back ▫ Neck ▫ Fall Risk ▫ TKR ▫ THR ▫ PWB ▫NWB
Comments:_____

Neuro Assessment ▫ →WFL
▫ Ataxia ▫ Tremors ▫ Rigidity ▫ Bradykinesia
▫ Spasticity ▫ Hypotonocity ▫ Paraplegia ▫ Hemiplegia R/L
▫ Incomplete Quadriplegia ▫ Complete quadriplegia
Comments:_____
_____

Cardio Pulmonary Assessment ▫ WFL
▫ Abnormal: _____
▫SOB ▫ Use of Oxygen__liters per min ▫continuous ▫PRN
▫ sitting X__min, ▫standingX___min ▫walkingX__min
Comments: _____
_____

Physical Impairment
- ROM/Flexibility
- Strength
- Balance
- Endurance
- Pain
- ▫ _____

Functional Limitation:
- ▫ ADL
- ▫ Functional Mobility
- ▫ Gait
- ▫ Falls
- ▫ Safely
- ▫ _____

Pt. Rehab Goals ▫ Return to Prior Level of Function ▫ Other: _____

Pt. is homebound ▫ No ▫ Yes, Restricted/ needing assistance to leave Rehab Potential for goals ▫ Poor, ▫ Good, ▫Fair, ▫Excellent

Complicating Factors that restrict Full Rehab Potential ▫ Multiple Diagnosis, ▫ Chronic Disease, ▫ Environmental Barriers, ▫ Motivation, ▫ Cognition ▫ Chemo/ Radiation, ▫ Nutrition, ▫ Obesity, ▫ Smoking, ▫ Alcohol Abuse, ▫ weight bearing status, ▫ Pain threshold, ▫_____

Short Term Goals _____Weeks
- ▫ Increase ROM_____
- ▫ Increase Strength _____
- ▫ Increase Balance_____
- ▫ Increase bed mobility_____
- ▫ Increase transfers _____
- ▫ Improve ambulation_____
- ▫ Improve endurance _____
- ▫ Decrease pain level _____
- ▫ Pt. & C/G independent in safety precautions/positioning
- ▫ Pt. & C/G independent in home exercise program
- ▫ _____
- ▫ _____
- ▫ _____

Long Term Goals: _____Weeks
- ▫ Increase ROM_____
- ▫ Increase Strength _____
- ▫ Increase Balance_____
- ▫ Increase Bed Mobility _____
- ▫ Increase transfers _____
- ▫ Improve ambulation _____
- ▫ Improve endurance _____
- ▫ Decrease pain level_____
- ▫ Pt. &C/G independent in fall recovery plan
- ▫ Pt. & C/G independent in progression of home exercise program
- ▫ _____
- ▫ _____
- ▫ _____

PLAN OF CARE: ▫ B1 Evaluation ▫ B2 Establish/Upgrade HEP ▫ B7 Home Safety Education
▫ B2 Therapeutic Exercise ▫ B5 Gait Training ▫ B8 Modalities: _____
INTERVENTIONS ▫ B3 transfer Training ▫ B6 Balance Training ▫ B12 Other:

Certification Period: From _____ to _____ Visit Frequency/Duration:_____

Total # of PT visits requested_____

▫ PTA notified of plan of care: _____

Physical Therapist's signature date of Verbal Order for Physical Therapy Plan of Care: Initial: _____Date:_____

Physical Therapist Signature: _____Date: _____

I certify that I have examined the patient, and therapy is necessary and that the services will be furnished while the patient is under my care and that the plan is established and will be reviewed every 30 day or more often of the patient's condition requires.

Physician Signature: _____ Date: _____