PT

# Skilled Treatment Note

| | | | |
|---|---|---|---|
| Services | Circle PT OT PTA COTA | Time In: | Time Out: |
| Patients Name: | | Date: | |
| Last: | First: | Patient Sign: | |

Coordination of Care

( ) PT_____ RN_____

( ) OT_____MSW_____

( ) ST_____ HHA_____

Pt /MD notified of D/C_____

Other:_____

HHA Evaluation

() Present (check if yes) ( ) Follow Plan
( ) Personal Care Given ( ) Services Change
__ Competence shown in Care (Services Changed)
Comments: _____
Name of HHA( if Present)

**Treatment Provided This Visit**

| **A. Instructions In:** | **D. General Modalities** | **H. Modalities** |
|---|---|---|
| Edema Control_____ | Evaluations_____ | _____ |
| Joint Protection Skills __ | Establish? Rev HEP_____ | _____ |
| Homemaking skills_____ | Teaching Caregiver_____ | **I. Transfer Training** |
| Energy Conservation Tech. __ | Notified MD/ Orders Received ____ | Rolling/bed mobility _____ |
| Adequate rest activity periods_____ | | Supine to/ from Sitting _____ |
| Back Precautions_____ | **E. Exercise** | Sit to from standing_____ |
| Hip Mechanics_____ | Therapeutic Ex's _____ | Bed to/ from W/C -BSC Chair |
| Body Mechanics_____ | ROM (Passive/A-A/Active)_____ | Shower/tub/toilet_____ |
| Pain management _____ | Stretching_____ | _____ |
| ROM Limitations_____ | Muscle Re-ed_____ | **J. Gait Training** |
| Positioning/ Turning _____ | Facilitation_____ | Walker _____ft. x_____ |
| Safety Measurements/Emergency Info _ | Coordination_____ | Quad Cane _____ft. x _____ |
| | Other_____ | Straight Cane _____ft. x_____ |
| **B .Pain Level (**circle) | **F. Perceptual Motor** | _____ |
| 0 1 2 3 4 5 6 7 8 9 10 | Spatial Relations_____ | _____ |
| Location_____ | Tactile Awareness_____ | |
| Relieved with _____ | Compensatory Techniques _____ | **K. ADL Training** |
| | Visual Perception _____ | Bathing UE/LE |
| **C. Adaptive Equipment** | Fine Motor Coordination _____ | Grooming |
| Evaluation | Handwriting _____ | Feeding |
| Instruct in use/Care | Other_____ | Dressing UE/LE |
| | **G. Balance Activities** | Other |
| | Sitting_____ | |
| | Standing_____ | |
| | | |
| | | |

## Assessment/Intervention

( ) Goals Reviewed ( ) MD Notified of D/C Planning

Plan:

Homebound Reason:

Therapist Signature: Date: