COUNTY HOSPITAL HOME HEALTH
JCAHO/MedicareMedicaid Certified

Physical Therapy Evaluation

❑ **Initial** ❑ **Re-evaluation**

Primary Dx (PT related) _____ Date of Onset / Exacerbation _____
Surgical Procedure _____ Date _____
Other Dx with Dates _____

Homebound Status: ❑ Needs assistance w/all activities ❑ Residual weakness ❑ SOB w/exertion ❑ Medical restrictions ❑ N/A ❑ Requires assistance to ambulate ❑ Confusion/Cognitive limitations ❑ Other: _____
Comments: _____
Precautions: ❑ N/A ❑ Unstable VS ❑ THR (R/L) ❑ Wt. Bearing _____ ❑ Falls ❑ Cardiac ❑ Pacemaker ❑ Secretions/drainage ❑ Other _____

Subjective
Hx: _____
Prior level of function _____
Patient goals _____

Objective: (Abbreviations for assistance required: I = independent, VC = verbal cures, CGA = contact guard, SBA = stand by, Min., Mod., Max.)
❑ Observations (v.s., posture, edema, wounds, etc.) _____

Range of Motion

Upper extremity, right	❑ WNL	❑ WFL	❑ Impaired	_____
Upper extremity, left	❑ WNL	❑ WFL	❑ Impaired	_____
Lower extremity, right	❑ WNL	❑ WFL	❑ Impaired	_____
Lower extremity, left	❑ WNL	❑ WFL	❑ Impaired	_____

Comments: _____

Strength

Upper extremity, right	❑ WNL	❑ WFL	❑ Impaired	_____
Upper extremity, left	❑ WNL	❑ WFL	❑ Impaired	_____
Lower extremity, right	❑ WNL	❑ WFL	❑ Impaired	_____
Lower extremity, left	❑ WNL	❑ WFL	❑ Impaired	_____

Comments: _____

Neurologic	**Sensation: light touch**	**Sensation: sharp/dull**	**Proprioception**
Upper extremity, right	❑ Intact ❑ Impaired ❑ Absent	❑ Intact ❑ Impaired ❑ Absent	❑ Intact ❑ Impaired ❑ Absent
Upper extremity, left	❑ Intact ❑ Impaired ❑ Absent	❑ Intact ❑ Impaired ❑ Absent	❑ Intact ❑ Impaired ❑ Absent
Lower extremity, right	❑ Intact ❑ Impaired ❑ Absent	❑ Intact ❑ Impaired ❑ Absent	❑ Intact ❑ Impaired ❑ Absent
Lower extremity, left	❑ Intact ❑ Impaired ❑ Absent	❑ Intact ❑ Impaired ❑ Absent	❑ Intact ❑ Impaired ❑ Absent

❑ Other/comments (DTRs, pathological reflexes, etc.) _____
❑ Abnormal tone _____

Patient Name: _____ **Patient ID No.:** _____ **Date:** _____

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Pain Scale:

(With 10 being worst possible)

	0	1	2	3	4	5	6	7	8	9	10
Before: _____											
During: _____											
After: _____	0 No Hurt		2 Hurts Little Bit		4 Hurts Little More		6 Hurts Even More		8 Hurts Whole Lot		10 Hurts Worst

❑ Intermittent ❑ Constant ❑ Sharp ❑ Dull ↑ W/_____ ↓ W/_____

Physical Therapy Evaluation

Mobility/Transfers	**I**	**VC**	**CGA**	**SBA**	**Min**	**Mod**	**Max**	**Dependent**	**Comments**
❑ Rolling	❑	❑	❑	❑	❑	❑	❑	❑	
❑ Scooting	❑	❑	❑	❑	❑	❑	❑	❑	
❑ Supine ↔ Sit	❑	❑	❑	❑	❑	❑	❑	❑	
❑ Sit ↔ Stand	❑	❑	❑	❑	❑	❑	❑	❑	
❑ Level surface transfer	❑	❑	❑	❑	❑	❑	❑	❑	
❑ Unlevel surface transfer	❑	❑	❑	❑	❑	❑	❑	❑	
❑ Commode/Bath transfer	❑	❑	❑	❑	❑	❑	❑	❑	
❑ Car transfer	❑	❑	❑	❑	❑	❑	❑	❑	
❑ Floor ↔ Stand	❑	❑	❑	❑	❑	❑	❑	❑	
❑ Wheelchair mobility	❑	❑	❑	❑	❑	❑	❑	❑	

Balance (grade 1 - 7, 1 = requires max support, 4 = independent without support but holds against no force, 7 = against max force/normal)

Standing w/device Static_____ Dynamic_____ ❑ Balance reactions: ❑ Present ❑ Impaired ❑ Absent

❑ Standing w/o device Static_____ Dynamic_____ ❑ Functional reach _____

Sitting Static_____ Dynamic_____

❑ Other/comments: _____

Coordination ❑ WNL ❑ Impaired_____

Gait

Assistive device: ❑ Noe ❑ Straight cane ❑ Small base quad cane ❑ Large base quad cane ❑ Hemi-walker

❑ Axillary crutches ❑ Forearm crutches ❑ Walker ❑ Rolling walker ❑ Platform walker (R/L)

Wt. bearing limitations_____ (R/L) ❑ Patient compliant ❑ Patient non-compliant

	I	**VC**	**CGA**	**SBA**	**Min**	**Mod**	**Max**	**Dependent**	**Description of gait deviations:**
Even surface	❑	❑	❑	❑	❑	❑	❑	❑	
Uneven surface	❑	❑	❑	❑	❑	❑	❑	❑	
Incline/decline	❑	❑	❑	❑	❑	❑	❑	❑	
↑ ↓ Steps	❑	❑	❑	❑	❑	❑	❑	❑	

Supplies

Quantity	Description	Quantity	Description

Patient/Caregiver's Agreement to Plan
Your physician has ordered the services listed below be provided to you on an intermittent basis. If you have a preference, indicate the day and time you would prefer our service. Our staff will try to honor your request if possible. You will be notified in advance of any schedule changes.

	Frequency/Duration	Preference (Day/Time)
Physical Therapy		

Patient/Caregiver's Signature:_____

Physical Therapy Evaluation

I, _____ certify that the employee arrived at _____ am/pm, left at _____ am/pm, and
(Patient/Caregiver Signature)
provided satisfactory care.

Exclusion Time: _____ **Reason for Exclusion:**_____

I certify that these notes: (1) are true and do not omit any material fact(s) that would mislead about the patient's status; and (2) were not prepared or changed by any supervisor, nor did any supervisor require me to change these notes, in any manner that is untrue, inaccurate or misleading. Signature/Title: _____ Date:_____

Complete this information only if the patient is not admitted

NON-ADMIT INFORMATION
Reason for Non-Admission

- ❑ Appropriate level services not approved by payor
- ❑ Another company already providing requested services
- ❑ Services ordered not medically necessary/indicated
- ❑ Environment unsafe/inappropriate of carrying out plan of care
- ❑ Hot Homebound
- ❑ Denial of requested services/equipment by payor
- ❑ Patient and/or caregiver request
- ❑ Physician request
- ❑ Unable to provide services requested by patient and/or caregiver

Therapist's Name _____ Date_____

Non-Admit Notifications:	**DATE**	**SIGNATURE**	**COMMENTS**
Doctor Notified	____/____/____	_____	_____
Referral Source Notified	____/____/____	_____	_____
Notice of Non-Coverage	____/____/____	_____	_____
Non-Admit Information Filed	____/____/____	_____	_____

Patient Name: _____ **Patient ID No.:**_____ **Date:**_____