**DATE: \_\_\_\_\_\_\_\_\_\_** Visit length\_\_\_\_\_\_ Discipline \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  | **PHYSICAL THERAPY EVALUATION** |
|  | **PHYSICAL THERAPY re-EVALUATION** |

Diagnosis as listed in patient chart, with the following relevant information:

(precautions, old injuries, social/emotional/financial status, past level of function and interests)

Prior level of function and living situation:

**Current Level of Function**

Bed Mobility

Bathroom Mobility

Ability to get out of room

ROM / Strength / limits

Pain

ADL level of assist:

Cognition: safety awareness, initiation, follow-through, self-advocacy

Engagement in exercise, mobility, activity options, visitors

**PLAN:**

Physical Therapy : FREQUENCY: \_\_\_\_\_\_\_ x’s per week or month

DURATION: \_\_\_\_\_\_\_\_\_ # of weeks (up to the two month certification period. OK to go over two months after talking with TIYH. OK to put on hold. Include in your plan

\_\_\_ Therapy training of facility aides expected to occur \_\_\_\_\_\_\_\_\_\_\_\_; may cover: \_\_safety;

\_\_\_ transfers; \_\_\_feeding; \_\_\_ADLS; \_\_\_engagement; \_\_\_using appropriate cues;

\_\_\_ ideas for cues/language; \_\_\_other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Therapy training of family or engagement of other community support: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LONG TERM GOAL**:

**SHORT TERM GOAL:** What performance will change; measured how, with how much help, under what conditions, for how long (Pick two or three goals, below)

Able to

Has rom to

Has strength to

Transfer skills to

Balance to

Gait to

Caregiver able to

Follows through with

Other

**Therapist Signature:** **Date:**

**CERTIFICATION OF PLAN OF CARE BY MD:**

**\_\_\_\_** **I agree** with this plan and the medical information is complete.

\_\_\_\_ Other medical issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ **I disagree** with this plan because \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Physician’s Name Date Signature**

**\*\*Please fax this information to confidential fax: 877-334-0714 2-18-19**