**Visit Length**:

**Evaluation referred by**: **To assess**:

Medical and treatment diagnosis:

Other factors impacting function:

Prior Level of function:

Current Level of Function:

Currently living in with

**PHYSICAL STATUS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Joint or Muscle group (HANDS, UE, TRUNK, NECK, LE)** | **Muscle functions: tone, strength, endurance**0 No muscle activation1 Trace muscle activation 2 Muscle activation with gravity eliminated 3 Muscle activation against gravity 4 Muscle activation against some resistance 5 Muscle activation against resistance  | **Joint functions: stability, alignment, range, speed of movement, stiffness, joint swelling, coordination**1. Uses frequently for ADLS
2. Uses with difficulty
3. Impairs ADLS
4. Unable
 | **Comments /areas of concern including PAIN** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**GAIT**: Unsteady\_\_\_\_\_\_\_\_\_\_\_\_\_; Shuffling\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Stance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BALANCE**: Tinetti Score: \_\_\_\_\_\_\_; Risk of falls: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PAIN**: Locations: Grades (0-10):

Control Measures and efficacy:

**COGNITION and PERCEPTION**:

**FUNCTIONAL MOBILITY and ADLs**:

**Vital signs and wound status**:

**OTHER**:

**ASSESSMENT**:

**Treatment Provided Today**:

**Recommendations**:

**FREQUENCY**: \_\_\_\_ x’s per week or month **DURATION**: \_\_\_\_ # of months

**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 8-31-19**