

PHYSICAL THERAPY REVISIT NOTE

DATE OF SERVICE ____/____/____
TIME IN ____ TIME OUT ____

VITAL SIGNS: Temp: ____ Pulse: ____ Regular/Irregular Resp.: ____ B/P: ____
Using O₂ at ____ LPM via: ____
PAIN: Rating scale: 0 1 2 3 4 5 6 7 8 9 10 Current pain level: ____
 No pain Mod pain Worst pain (subjective reporting)
Pain quality: ____ Pain location: ____ Frequency: ____
 (ache, sharp, etc.)

TYPE OF VISIT:
 Revisit and Supervisory Visit
SOC DATE ____/____/____
 G0151 PT G0157 PTA

HOMEBOUND REASON: Needs assistance for all activities Residual weakness
 Requires assistance to ambulate Confusion, unable to go out of home alone
 Unable to safely leave home unassisted Severe SOB, SOB upon exertion
 Dependent upon adaptive device(s) Medical restrictions
 Other (specify) _____

Safety Issues:
 Obstructed pathways Home environment
 Stairs Unsteady gait
 Verbal cues required
 Equipment in poor condition Bathroom
 Commode
 Others (specify): _____

Treatment Diagnosis/Problem Area(s): Impaired gait quality, posture, deviation
 Coordination deficits (Fine/Gross) Decreased independence with functional transfers
 Lower body weakness/limited ROM Impaired balance, loss of balance
 Increased falls Limited functional mobility (w/c, ambulation, etc.)
 Impaired functional ambulation Other: _____

Referral Made: Yes No If Yes (specify) _____

PHYSICAL THERAPY INTERVENTIONS

<input type="checkbox"/> Establish HEP: <input type="checkbox"/> Given to Pt <input type="checkbox"/> In Chart	<input type="checkbox"/> Therapeutic Exercise <input type="checkbox"/> Neuro-Muscular Re-education	<input type="checkbox"/> Modalities: <input type="checkbox"/> TENS <input type="checkbox"/> Ultrasound <input type="checkbox"/> E-stim	<input type="checkbox"/> Orthotic Fitting/Fabrication/Training <input type="checkbox"/> Prosthetic Fitting/Fabrication/Training
<input type="checkbox"/> Patient/Family/Caregiver Education	<input type="checkbox"/> Gait Training	<input type="checkbox"/> Heat <input type="checkbox"/> Ice	<input type="checkbox"/> Functional Mobility
<input type="checkbox"/> Adaptive Equipment Training	<input type="checkbox"/> Balance	<input type="checkbox"/> Pulmonary PT	<input type="checkbox"/> Other: _____

GOALS/OUTCOMES: Patient/Therapist identified functional based goals (areas identified in evaluation)

Functional Goal Area Focused On:	Performance/Progress toward Functional Task:	Barriers towards Independence:

Adaptive Equipment Needs Identified and/or Trained on: _____ Patient/Caregiver/Family Response: _____

Demonstrates Rehab Potential as: Poor Fair Good Excellent
Patient demonstrates potential for continued gains towards a greater level of functional independence and will benefit from continued Physical Therapy Services to address deficit areas impacting his/her function. Please see Physical Therapy Evaluation and Plan of Care for further detailed information regarding current functional level and areas of focus.

CARE PLAN: Reviewed/Revised with Patient/Caregiver/Family
Revised Yes No (specify): _____

APPROXIMATE NEXT VISIT DATE: ____/____/____
PLAN FOR NEXT VISIT: _____
DISCHARGE PLAN DISCUSSED WITH: Patient/Family
 Care Manager Physician Other: _____
BILLABLE SUPPLIES USED? N/A Yes (specify): _____

CARE COORDINATION DISCUSSED WITH: Physician Nursing
 PT OT ST MSW Aide Other: _____

SUPERVISORY VISIT (Complete if applicable)
 PT Assistant Aide / Present Not present
Supervisory Visit: Scheduled Unscheduled
Observation of: _____

Teaching/Training of: _____

Next Scheduled Supervisory Visit: _____
Care plan reviewed/revised with assistant/aide during this visit:
 Yes No If yes (specify): _____
If PT assistant/aide not present, specify date he/she was contacted
regarding updated care plan: ____/____/____

Comments: _____

SIGNATURES/DATES

X _____ Patient/Caregiver (if applicable) Date ____/____/____	Complete TIME OUT (above) prior to signing below. _____ Therapist (signature/title) Date ____/____/____
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PATIENT NAME - Last, First, Middle Initial _____ ID# _____