



Plot QA

PHYSICAL THERAPY CLINICAL NOTE

Patient Name: _____ Episode # _____

Service Area of Dade: Service Area of Broward: Service Date: _____

Discipline: PT PTA Type of Note: Skilled Visit Supervisor Visit Discharge

Employee Name: _____ License #: _____

Payer Code: Medicare Medicaid Private Contract Insurance Staffing

Time In: _____ A.M. P.M. Time Out: _____ A.M. P.M. Total Time: _____

My signature on this form constitutes that the times affixed are correct and that work was performed in a satisfactory manner.

X _____
Care Plan was discussed with **Physical Therapist**.
(Patient Signature)

X _____
Florida Home Bound Representative Signature

Is the patient in an HMO? Yes No If Yes, please give name of HMO: _____

Homebound Status

- Anxious Medical condition restricts most activity Mental condition prevents leaving home
- Impaired reality Disoriented Confused Unsafe Impaired judgment
- Agoraphobic Depressed Refuses to leave home

Health Assessment

Pulse: _____ Resp: _____ B/P Sitting (Lt): _____ (Rt) _____ Standing (Lt): _____ (Rt) _____

Pain Scale: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Constant Intermittent Acute Chronic

Pain Location: _____

Patient compliant with pain management.

Respiratory System:

Dyspnea Scale: No dyspnea Mild, noticeable Mild, some difficulty Moderate difficulty, but can continue
 Severe difficulty, cannot continue

8. FUNCTIONAL LIMITATIONS

- Amputation Paralysis Legally Blind Endurance Dypnea W/Minimal Exertion
- Contracture Ambulation Hearing Speech General Weakness
- Arthralgia Pain on Ambulation Limited Mobility Dizziness Unsteady Gait
- Limited ROM Leg Cramps Chest Pain on Exertion Needs Assist of 1-2 Persons
- SOB on Exertion Fatigue at times Low Vision Weak Legs Back Pain

PHYSICAL THERAPY CLINICAL NOTE

Patient Name: _____ Episode # _____

PT TREATMENT

- Gait Training: NWB, TTWB, PWB, WBAT, Surfaces, Distance
Walker, Crutches, Quad Cane, Straightcane
Transfer Training: Bed, Chair, Wheelchair, Bed Mobility
Therapeutic Exercises: Passive, Active Assisted, Active, Isometric, Other
Wheel Chair Mobility:
Balance: Stand, Static, Dynamic, Sit, Static, Dynamic
Breathing Treatment: Postural Draining, Chest Percussion, Breathing Exercise
Electrotherapy: Tens, FES
Ultrasound, Infrared Laser, Other
Cold Pack, Ice Massage, Moist Heat
Soft Tissue Mobilization Treatment
Manual Physical Therapy, Pain Management
Prosthetic Training, Orthotic Training, Muscle Re-education for
Home Exercise Program: Establish HEP, Upgrade HEP, Copy in Home: Yes, No
HEP description
Management of Patient Care, Management of Caregiver with Patient Care
Evaluation of Patient Care, Evaluation of Caregiver with Patient Care
Caregiver able to demonstrate knowledge: Yes, No, N/A

10. Other Skilled Int. completed this visit: Universal Precautions maintained thru visit

Response to Treatment:

Patient has potential for improvement and restoration of function to establish a safe and effective maintenance program.
Progress Towards Goals: Poor, Fair, Moderate, Good Comment:

Skill Instructions Provided To: Patient, Caregiver
Instructed on

Outcome: Verbalizes: No knowledge, Minimal knowledge, Moderate knowledge, Substantial knowledge
Demonstrates: No skill, Minimal skill, Moderate skill, Substantial skill
What got in the way of learning?: Medication effect, Medical condition, Anxiety, Depression
Confusion, Distraction, Forgetfulness, Other

PTA/HHA Supervisory visit done: Yes, No Plan meets patient care needs: Yes, No
Care Plan reviewed: Yes, No Patient satisfied with care: Yes, No
Care Plan followed: Yes, No Home Visit completed according to M.D. Orders: Yes, No
Care is being provided according to POC: Yes, No
Communications With: MD, RN, PT, OT, SLP, MSW, Aide, Other
Name: RE:
Continue care - Patient remains homebound and requires skilled care for
Discharge planned for Discharge planning discussed with Patient, Caregiver
Completed. Patient discharged/instructions given to: Patient, Caregiver
Is Patient requesting a Skill Nurse? Yes, No Is Patient requesting a Social Worker? Yes, No

Therapist Signature/Title: LIC # Date: