morningstar Home Health agency, inc.

PHYSICAL THERAPY VISIT NOTE

			DATE OF SERVICE/_	<u>/</u>
			TIME INOUT	
OMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residue ☐ Requires assistance to ambulate ☐ Confusion, unable to go o ☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exit in Dependent upon adaptive device(s) ☐ Medical restrictions ☐ Other (specify)		xertion	TYPE OF VISIT: ☐ Revisit ☐ Revisit and Supervisory Visit ☐ Other (specify) SOC DATE	
REATMENT DIAGNOSIS/PROBLEM				
				
XPECTED TREATMENT OUTCOME(S	S)			
SUVELCAL THERAPY IN	TERVENTIONS/INSTR	CUCTIONS (Mark	all applicable with an "X".) CPM (specify)	
Evaluation (BI)	Pulmonary Fitysion: //	erapy (B6)	CPM (specify) Functional mobility training	
Establish rehab, program	Ultrasound (B7)		Teach bed mobility skills	
Establish home exercise program	Electrotherapy (B5)		Teach hip safety precautions	
☐ Copy given to patient/client	Prosthetic training (B9)	<u> </u>	Teach safe/effective use of adaptive/as	selet
☐ Copy attached to chart	Preprosthetic training	douglas (RTO)	device (specify)	
Patient/Client/Family education	Fabrication of orthotic Muscle re-education (8		Teach safe stair climbing skills	
Therapeutic exercise (B2)	Muscie re-edication (t	etion of care plan (B12)	Other:	
Transfer training (B3)	TENS			
Home program (84) Establish / Upprade	Cardiopulmonary PT			
Gait training (B5)	Pain Management	 	<u> </u>	
Balance training/activities		3450		
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Balance training activities  BSERVATIONS, INSTRUCTIONS AN				~
VALUATION AND PATIENT/CLIENT/	CAREGIVER RESPONSE	SÜPERVIS	ORY VISIT (Complete if applicable	
VALUATION AND PATIENT/CLIENT/  ARE PLAN: □ Reviewed/Revised with if revised, specify	CAREGIVER RESPONSE	SUPERVIS  PT Assistant D A  SUPERVISORY VISI	ORY VISIT (Complete if applicable ide / □ Present □ Not present ↑ □ Scheduled □ Unscheduled	· · · · · · · · · · · · · · · · · · ·
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