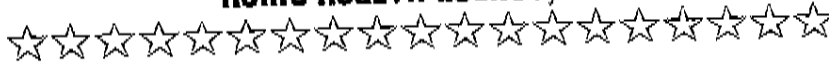




MORNINGSTAR Home Health Agency, Inc.



PHYSICAL THERAPY VISIT NOTE

DATE OF SERVICE / / TIME IN OUT

- 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)

TYPE OF VISIT: Revisit, Revisit and Supervisory Visit, Other (specify), SOC DATE / /

TREATMENT DIAGNOSIS/PROBLEM, EXPECTED TREATMENT OUTCOME(S)

PHYSICAL THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X")

Table with 3 columns: Intervention/Instruction (e.g., Evaluation (B1), Establish rehab. program), Pulmonary Physical Therapy (B6) (e.g., Ultrasound (B7), Electrotherapy (B8)), and CPM (specify) (e.g., Functional mobility training, Teach bed mobility skills).

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES

EVALUATION AND PATIENT/CLIENT/CAREGIVER RESPONSE

CARE PLAN: Reviewed/Revised with patient/client involvement, Outcome/instruction achieved, PRN order obtained, APPROXIMATE NEXT VISIT DATE, DISCHARGE DISCUSSED WITH, BILLABLE SUPPLIES RECORDED?, CARE COORDINATION

SUPERVISORY VISIT (Complete if applicable), PT Assistant, Aide, Present, Not present, SUPERVISORY VISIT, SCHEDULED, UNSCHEDULED, OBSERVATION OF, TEACHING/TRAINING OF, PATIENT/CLIENT/FAMILY FEEDBACK ON SERVICES/CARE, NEXT SCHEDULED SUPERVISORY VISIT, CARE PLAN UPDATED?, If PT assistant/aide not present, specify date he/she was contacted regarding updated care plan

SIGNATURES/DATES

Complete TIME OUT (above) prior to signing below. Therapist (signature/title), Date

PART 1 - Clinical Record

PART 2 - Therapist

PATIENT/CLIENT NAME - Last, First, Middle Initial, ID#