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".)

Evaluation (B1)	Pulmonary Physical Therapy (B6)	CPM (specify)
Establish rehab. program	Ultrasound (B7)	Functional mobility training
Establish home exercise program	Electrotherapy (B8)	Teach bed mobility skills
☐ Copy given to patient/client	Prosthetic training (B9)	Teach hip safety precautions
☐ Copy attached to chart	Preprosthetic training	Teach safe/effective use of adaptive/assist
Patient/Client/Family education	Fabrication of orthotic device (B10)	device (specify)
Therapeutic exercise (B2)	Muscle re-education (B11)	Teach safe stair climbing skills
Transfer training (B3)	Management and evaluation of care plan (B12)	Other:
Home program (B4) Establish / Upgrade	TENS	
Gait training (B5)	Cardiopulmonary PT	
Balance training/activities	Pain Management	

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES _____

EVALUATION AND PATIENT/CLIENT/CAREGIVER RESPONSE _____

CARE PLAN: ☐ Reviewed/Revised with patient/client involvement.
If revised, specify _____

☐ Outcome/instruction achieved (describe) _____

☐ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ___/___/___
PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ☐ Patient/Client/Family
☐ Care Manager ☐ Physician ☐ Other (specify) _____
BILLABLE SUPPLIES RECORDED? ☐ N/A ☐ Yes (specify) _____

CARE COORDINATION: ☐ Physician ☐ PT ☐ OT ☐ ST ☐ SS
☐ SN ☐ Other (specify) _____

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
(specify) _____

NEXT SCHEDULED SUPERVISORY VISIT ___/___/___
CARE PLAN UPDATED? ☐ No ☐ Yes (specify) _____

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#