| **Home Health VNA**<br>**Outpatient Therapy**<br>**PT / OT Evaluation**<br>**Page 1** | Name:<br>MD Name:<br>Policy #:<br>Medical Dx:<br>TxDx: | DOB<br>MR#<br>Provider #:<br>Onset Date:<br>SOC: |
|---|---|---|

**Date:** ____________ **Co-morbidities/Precautions:**_______________________________________________

**Pertinent Medical History** (Medical Hx Questionnaire reviewed –**Yes** ) (**reported tests/prior treatment**): ___________________

_______________________________________________________________________________

_______________________________________________________________________________

**Were Barriers to Learning Identified? :** ❐**No** ❐**Yes, comments:** ________________________________

**Cognition:** ❐ Follow 1 step command ❐ Follow 2 step commands ❐ Follow complex commands ❐ Other _____________

**Were potential social or vocational adjustment service needs identified? :** ❐ **No** ❐ **Yes, Comments:**

- ❐ Issues will be addressed in ***PT / OT*** plan of care
- ❐ Issues are currently being addressed outside HH VNA (Meds, therapy etc.) to patient satisfaction
- ❐ Upon review of issues, patient has chosen to: ❐discuss treatment options with PCP
- ❐ Patient does not wish to seek intervention for identified issues

**Employment status: N/A Retired OOW LD FD comments:** ______________________________________

**Patient Goals**: ______________________________________________________________________

**Prior Level of Function:** _______________________________________________________________

_______________________________________________________________________________

**Area to be Addressed In POC**

**Present Level of Function:**

Self Care/ ADL's: ❐ WNL or ❐ Limited with ______________________________________________ ❐

_______________________________________________________________

Home Management: ❐ WNL or ❐ Limited with ______________________________________________ ❐

_______________________________________________________________

Sit/Drive tolerance: ❐ WNL or ❐ Limited with ______________________________________________ ❐

Stand tolerance: ❐ WNL or ❐ Limited with ______________________________________________ ❐

Sleep tolerance: ❐ WNL or ❐ Limited with ______________________________________________ ❐

Work tolerance: ❐N/A ❐ WNL or ❐ Limited with ______________________________________________ ❐

Recreation/Leisure: ❐ WNL or ❐ Limited with ______________________________________________ ❐

**Mobility:**

Bed Mobility: ❐ WNL or ❐ Limited with ______________________________________________ ❐

_______________________________________________________________

Transfers: ❐ WNL or ❐ Limited with ______________________________________________ ❐

_______________________________________________________________

Gait/Functional Ambulation: ❐ WNL or ❐ Limited with ________________________________________ ❐

Stairs: ❐ WNL or ❐ Limited with ______________________________________________ ❐

W/C management/propulsion ❐ N/A ❐ WNL or ❐ Limited with ___________________________________ ❐

**Balance/Safety/Risk for falls:**

In Home ❐ WNL or ❐ Limited with ______________________________________________ ❐

In Community ❐ WNL or ❐ Limited with ______________________________________________ ❐

**Pain:** (0-10) Range: (low-high) ____ - ____ Daily Average: _____ Location _________________ Type _______ ❐

**Vitals:** ❐ After review of PMH, assessment of vitals not warranted ❐ HR___________ BP_______________ ❐

**Tone:** ❐ WNL _________________________________________________________________ ❐

**Sensation:** ❐ WNL ______________________________________________________________ ❐

**Coordination:** ❐ WNL ____________________________________________________________ ❐

**Comments:** ___________________________________________________________________

| Home Health VNA<br>Outpatient Therapy<br>PT Evaluation<br>Page 2 | Name:<br>MD Name:<br>Policy #:<br>Medical Dx:<br>TxDx: | DOB<br>MR#<br>Provider #:<br>Onset Date:<br>SOC: |
|---|---|---|

## CERVICAL / UPPER EXTREMITY STRENGTH AND RANGE OF MOTION

| Hand Dominance<br>❒ Right ❒ Left | | LEFT STR | LEFT ROM | RIGHT STR | RIGHT ROM | Comments<br>* = painful | To be Addressed In POC |
|---|---|---|---|---|---|---|---|
| **SHOULDER** | Flexion 0-180 | | | | | | ❒ |
| | Extension 0-60 | | | | | | ❒ |
| | Abduction 0-180 | | | | | | ❒ |
| | Internal rot 0-70 | | | | | | ❒ |
| | External rot 0-90 | | | | | | ❒ |
| **ELBOW** | Flexion 0-150 | | | | | | ❒ |
| | Extension 0-0 | | | | | | ❒ |
| **FOREARM** | Pronation 0-80 | | | | | | ❒ |
| | Supination 0-80 | | | | | | ❒ |
| **WRIST** | Flexion 0-80 | | | | | | ❒ |
| | Extension 0-70 | | | | | | ❒ |
| **CERVICAL ROM** | | | | | | | ❒ |

## LUMBAR / LOWER EXTREMITY STRENGTH AND RANGE OF MOTION

| | | LEFT STR | LEFT ROM | RIGHT STR | RIGHT ROM | Comments<br>* = painful | |
|---|---|---|---|---|---|---|---|
| **HIP** | SLR 0-80 | | | | | | ❒ |
| | Flexion 0-120 | | | | | | ❒ |
| | Extension 0-25 | | | | | | ❒ |
| | Abduction 0-45 | | | | | | ❒ |
| | Internal rot 0-45 | | | | | | ❒ |
| | External rot 0-45 | | | | | | ❒ |
| **KNEE** | Flexion 0-135 | | | | | | ❒ |
| | Extension 0-0 | | | | | | ❒ |
| **ANKLE** | Dorsiflex 0-20 | | | | | | ❒ |
| | Plantarflex 0-50 | | | | | | ❒ |
| | Inversion 0-35 | | | | | | ❒ |
| | Eversion 0-20 | | | | | | ❒ |
| **LUMBAR ROM** | | | | | | | ❒ |

**Reflexes:** ________________________________________ **Myotomes:** ________________________________________

**Palpation:** ______________________________________________________________________________ ❒

______________________________________________________________________________________

**Body Mechanics/Posture:** ___________________________________________________________ ❒

**Special Tests:**____________________________________________________________________ ❒

**Gait:** ❒ N/A ❒ WFL ❒ Impaired: Device _______ Level of Assist ______ Distance ______ Surface _____________ ❒

Pattern: ___________________________________________________________________________

_______________________________________________________________________________

**Equipment use or need:** ❒ N/A ___________________________________________________________ ❒

**Patient/ Family Teaching:** ❒ HEP issued ____________________________________________________ ❒

| Home Health VNA<br>Outpatient Therapy<br>PT / OT Evaluation<br>Page 3 | Name:<br>MD Name:<br>Policy #:<br>Medical Dx:<br>TxDx: | DOB<br>MR#<br>Provider #:<br>Onset Date:<br>SOC: |
|---|---|---|

## Assessment / Plan of Care

Patient was seen by ***Home Health VNA*** for ***PT / OT*** evaluation per physician referral on ____________ (SOC). Co-morbidities of: ________________________________________ were identified and taken into consideration in POC. Therapist prescribed therapeutic interventions based on functional assessment as follows:

**INITIAL ASSESSMENT:** Pt is a ____ yo ____ with c/o ______________________________________________
______________________________________________________________________________

The following PT / OT **problems** were noted upon evaluation: ________________________________________
______________________________________________________________________________

These problems limit the patient with the following **functional activities**: ________________________________
______________________________________________________________________________
______________________________________________________________________________

This patient ***will / will not*** benefit from designed, skilled ***PT/OT*** plan of care and demonstrates **Poor Fair Good Excellent** rehabilitation potential to attain established STG's, LTG's and to maximize functional independence. The prescribed treatment plan of care is medically necessary secondary to: ______________________________
___________________________ (Rehab Dx). Patient requires skilled assessment weekly to adjust plan of care.

| STG ( ____ weeks) | LTG ( _____ weeks ) |
|---|---|
| | |
| | |
| | |
| | |
| | |

**TREATMENT PLAN:** Frequency: ____x/wk Duration: ____ wks Time Frame: ________ to _________

| | | |
|---|---|---|
| ❒ HP/CP (97010) | ❒ Ther ex (97110) | ❒ Manual Tech (97140) |
| ❒ Pt/family train/HEP | ❒ Ther act (97530) | ❒ Neuro Re-ed (97112) |
| ❒ Ultrasound (97035) | ❒ Gait Train (97116) | ❒ Mech Traction (97012) |
| ❒ Orthotic Train (97035) | ❒ Direct E-stim (97032) | ❒ Self Care (97535) |
| ❒ L code/ custom orthotics___________ | ❒ Contrast bath(97034) | ❒ Sup E-stim (G0283/97014)<br>❒ ______________________ |

Plan of care discussed with Patient/Family: ❒ Yes ❒ No Patient/Family agrees with plan of care: ❒ Yes ❒No

Patient goals reviewed and incorporate in POC: ❒ Yes ❒ No Patient/Family Education ❒ Yes ❒ No _________________

**PT/OT Signature**__________________________________________________ Date: _________ Time: ________

| **Home Health VNA**<br>**Outpatient Therapy**<br>**PT / OT Weekly Progress Note** | Name:<br>MD Name:<br>Policy #:<br>Medical Dx:<br>TxDx: | DOB<br>MR#<br>Provider #:<br>Onset Date:<br>SOC: |
|---|---|---|

**Date of Report:** _________ **Number of Visits since SOC:** ______ **Weekly Note Due:** ________________

**SUBJECTIVE:** Pain Level (0-10) ____/10 Location:____________________ Medication/ PMH Changes: Yes / No
Patient / Caregiver report: ______________________________________________________________

**OBJECTIVE:**

| **Objective Measures**<br>❒HEP<br><br>❒Other: | **HEP is established / monitored / adjusted / progressed**<br>**Compliance: Y / N Carryover: Good / Fair / Poor**<br>**Comment/Description:** |
|---|---|
| **Function**<br>❒Home Safety<br>❒Home Mgmt ↑ ↓ = | **Comment/Description:** |
| **Mobility**<br>❒Gait Technique<br>❒Transfers ↑ ↓ =<br>❒Stairs ↑ ↓ =<br>❒Balance/Safety ↑ ↓ = | **Comment/Description:** |

**Modalities:** Patient's Response: ____________________________________________________________

**Patient / Family Education:** _____________________________________________________________

**ASSESSMENT**:_________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Patient has ***good/fair/limited*** gains in all areas of plan of care addressed this week. Patient continues to require the skills of a therapist secondary to ____________________________________________________________. Treatment services continue to be reasonable and necessary based upon stated progress. Patient services ***remain / are not*** medically necessary. Patient would continue to benefit from ***PT / OT*** in order to attain stated STG's, LTG's and to achieve functional independence.

| STG's (Weekly) | Met | Not Met | New STG (Weekly) | New/ Revised/ Carryover |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

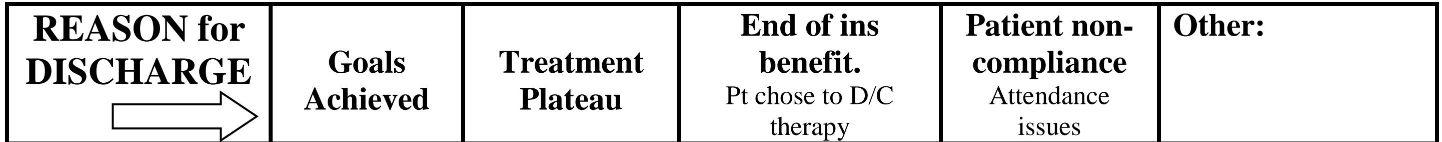
**PLAN:** Frequency/Duration: ____ x/week for ____ weeks Estimated D/C Week ___________
Discharge Plan Discussed Y / N Modification to POC: ________________________________________

Signature: ______________________________________________ Date: _______________ Time: ________________

| **Home Health VNA**<br>**Outpatient Therapy**<br>**OT/ PT Discharge Summary** | Name:<br>MD Name:<br>Policy #:<br>Medical Dx:<br>TxDx: | DOB<br>MR#<br>Provider #:<br>Onset Date:<br>SOC: |
|---|---|---|

# PT/ OT Discharge Summary

Patient received skilled PT/OT services by ***Home Health VNA*** for _____ visits from ____________ (initial eval date) to ________________ (discharge date). During this time the patient required the skills of a therapist to address LTG's and improve functional activities. Co-morbidities of: ______________________ were identified at initial evaluation and taken into consideration during patient's care.



| **REASON for DISCHARGE** ⇨ | **Goals Achieved** | **Treatment Plateau** | **End of ins benefit.** Pt chose to D/C therapy | **Patient non-compliance** Attendance issues | **Other:** |
|---|---|---|---|---|---|

**SUBJECTIVE:** Pain Level (0-10) ____/10 Patients own goals were **Met / Not Met / Partially Met.**
Patient / Caregiver Comments: ______________________________________________

**OBJECTIVE:** ❒ Refer to progress report dated on _____________ for objective and functional findings.

**Objective measures at Discharge:**
ROM: ❒WNL ❒WFL ❒limited: ________________________________________________
Strength: ❒WNL ❒WFL ❒limited: ________________________________________________
Other: ______________________________________________________________________

**Functional Status at Discharge:**
Self Care/ ADL's: ❒ WNL or ❒ Limited with ________________________________________
Home Management: ❒ WNL or ❒ Limited with ________________________________________
Sit/Drive tol: ❒ WNL or ❒ Limited with ________________________________________
Stand tol: ❒ WNL or ❒ Limited with ________________________________________
Sleep tol: ❒ WNL or ❒ Limited with ________________________________________
Work tol: ❒ N/A ❒ WNL or ❒ Limited with ________________________________________
Recreation/Leisure: ❒ WNL or ❒ Limited with ________________________________________

**Mobility at Discharge**
Bed Mobility: ❒ WNL or ❒ Limited with ________________________________________
Transfers: ❒ WNL or ❒ Limited with ________________________________________
Functional Ambulation: ❒ WNL or ❒ Limited with ________________________________________
Stairs: ❒ WNL or ❒ Limited with ________________________________________
W/C management/propulsion ❒ N/A ❒ WNL or ❒ Limited with _______________________________

**Balance/Safety/Risk for falls at Discharge**
In Home ❒ WNL or ❒ Limited with ________________________________________________
In Community ❒ WNL or ❒ Limited with ________________________________________________

**ASSESSMENT:** ______________________________________________________________________
___________________________________________________________________________________

**PLAN:** Patient is discharged from PT / OT with below recommendations:

❒ Follow Up with M.D.
❒ HEP – provided to patient / caregiver
❒ Gym Program
❒ Other ______________________________

❒ Discharge plan reviewed with patient / family.
❒ Patient / Family agreed / disagreed with plan.
❒ Patient discharged secondary to failure to return.

PT/OT Signature______________________________________________Date: _________ Time: _______