**Visit Length:**

**Evaluation referred by: To assess:**

Medical and treatment diagnosis

Current living situation:

Other factors impacting function:

Prior Level of function:

**ROM and STRENGTH:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Joint or Muscle group** |  **R** **ROM** | **L****ROM** | **R****Strength** | **L Strength** | **Muscle functions: tone, strength, endurance** | **Joint functions: stability, alignment, range** | **Comments /areas of concern** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**GAIT**: Unsteady\_\_\_\_\_\_\_\_\_\_; Shuffling\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Stance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BALANCE**: (Tinetti Score: \_\_\_\_\_\_\_; Risk of falls: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PAIN**: Locations: Grades (0-10): Control Measures and efficacy:

**COGNITION and PERCEPTION**:

**FUNCTIONAL MOBILITY and ADLs:**

**Vital signs and wound status**

**OTHER**:

**Treatment provided today and response**:

**ASSESSMENT**:

**FREQUENCY**: \_\_\_\_ x’s per week or month **DURATION**: \_\_\_\_ # of weeks

**LONG TERM GOAL**:

**Short term: PATIENT SPECIFIC FUNCTIONAL SCALE: Circle one of following G-code areas and add the word to the grid at functional limitation area, upper left of grid.** Mobility, Position, Handling, Self-Care, Other, Swallow, Attention, Memory, Motor Speech, Spoken Language Comp, Spoken Language Expr, Voice

|  |  |  |  |
| --- | --- | --- | --- |
| This is not a problem list, these are areas of engagement or function: What the client is UNABLE TO DO that is not up to par. Pick one or two, or add others if needed.  | **HOW MUCH does this problem interfere with activities or participation?**  | **Therapist’s goal**.  |  **10th visit or** DC Status:  |
| A. Due to pain unable to \_\_\_\_\_\_\_\_ B. Due to weakness or ROM unable to \_\_\_\_\_\_\_\_\_ C. Unsafe or unable transfer type \_\_\_\_\_\_D. Unable to feel confident with balanceE. Gait impairs \_\_\_\_\_\_\_\_D. CG unable to \_\_\_\_\_\_\_\_E. Is not following through with \_\_\_\_\_\_\_F. Other:  | 100% impaired to 0% impairedA. B. C. D.E.F.  | 100% to 0% impairedA. B. C. D. E.F.  | 100% to 0% impairedA. B.C.D.E.F. |
| **Average totals in the next three columns:** add scores and divide by # activities: i.e. If scores were 100% disabled, 90% and 70% = 100 + 90 + 60 = 150 divided by 3 areas = 50% disabled.  | Total: **This % goes in box A on grid** |  Total: **Box B and C on grid** | Total:**Box D on grid** |

**Therapist Signature:** **Date:**

**CERIFICATION OF PLAN OF CARE BY MD:**

**\_\_\_\_** **I agree** with this plan and the medical information is complete.

\_\_\_\_ Other medical issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ **I disagree** with this plan because \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Physician’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Please fax this information to confidential fax: 877-334-0714 1-4-19**

**information to confidential fax: 877-334-0714 01/04/19**