Cert Period:

Professional Nursing Service ☐ CHECK HERE IF NOT A VISIT

THERAPY Evaluation & Plan of Treatment Note

PHYSICIAN ORDERS ☐PT ☐OT ☐ST

☐ **INITIAL EVALUATION** ☐ **RE-EVALUATION** ☐ **HOLD** ☐ **DISCHARGE**

Payor Source _____ UHHC# _____ Patient Identifiers: ☐ Facial Recognition ☐ Patient Address ☐ DOB Initial Visit

Patient Name _____ D.O.B. _____

CURRENT STATUS: ☐ 60-Day Summary Dr. Name:_____

Pain: □ None □ Improved □ Worse Location(s) _____

Duration_____ Intensity 0-10 _____ Relief Measures_____

TREATMENT CODES / TREATMENT TO INCLUDE

	Est. / Teach / Upgrade Home Exercise Program		DME/Orthotics/Prosthetic/Assessment/Training/Modification		Speech Articulation Disorder Treatment
	Therapeutic Exercises		ADL Training		Voice Disorders Training
	Neuro-Muscular Re-Education		Perceptual Motor Training		Dysphagia Treatment
	Gait Training		Transfer Training		Language Disorders Treatment
	Gross Motor Skills Training		Sensory Motor Treatment		Aural Rehabilitation
	Other		Fine Motor Skills Training		Non-Oral Communication

Progress: □ Improved □ Unchanged □ Regression Comments: _____

Rehabilitation Potential: □ Excellent □ Good □ Fair □ Poor **Pt/Caregiver Compliance**: □ Excellent □ Good □ Fair □ Poor

Plan: □ Continue Therapy □ On Hold □ Discharge-Planned/Unplanned/Follow up by MD/Multidiscipline Contact Made □Other_____***SEE D/C STATUS BELOW***

DISCHARGE STATUS: ☐Goals Met/Achieved ☐Goals Partially Met ☐Minimal Progress ☐Non-Compliance ☐Maximum Benefits Achieved ☐Other_____

Frequency: _____(Format: #of visits/wk X # of wks)

SHORT TERM GOALS

Baseline Status/Current Status/D/C Status

1._____ _____
2._____ _____
3._____ _____
4._____ _____

LONG TERM GOALS

1._____ _____
2._____ _____
3._____ _____
4._____ _____

Physician Signature:	**Date:**

Therapists Signature/Lic#:	Patient / Caregiver Signature: **X**

Date: _____ Time In: _____ Time Out: _____