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: _____