McLaren FLINT

PHYSICAL THERAPY EVALUATION

Date of Prescription	TREATMENTS REQUESTED

DIAGNOSIS: ______________________ Age: ________

ASSOCIATED HISTORY: ☐ Per Chart ☐ Per pt: ______________________

____

X-RAYS/TESTS: ______________________

PAST MEDICAL HISTORY: ☐ Per Chart ☐ Per pt: ______________________

____

PRIOR LEVEL OF FUNCTION (PLOF): ______________________

SOCIAL ☐ Lives Alone ☐ Lives with/at: ______________________

STAIRS Into Home: # ________ Inside Home: # ________ Ascending Rails Outside: Rt/Lt:, Inside: Rt/Lt

WEIGHT BEARING STATUS ☐ R UE/LE ☐ L UE/LE ___ NWB ___ TTWB ___ PWB ___WBAT ___ Restrictions: ________

PREVIOUS HISTORY WITH ASSISTIVE DEVICES

☐ No ☐ Yes If yes, when: ________________ ☐ Standard Walker ☐ Rolling Walker

☐ Crutches ☐ Wheelchair ☐ Quad Cane ☐ Straight Cane ☐ Other: ________________

MENTATION ☐ WNL ☐ Impaired ☐ Motivated ☐ Unmotivated Comments: ________________

ORIENTATION ☐ Person ☐ Place ☐ Time ☐ Situation Comments: ________________

PATIENT'S GOALS ______________________

GROSS STRENGTH

Upper Extremity: Functional: Rt/Lt Non-Functional: Rt/Lt

Lower Extremity: Functional: Rt/Lt Non-Functional: Rt/Lt

RANGE OF MOTION: ACTIVE/PASSIVE

Upper Extremity: Functional: Rt/Lt Non-Functional: Rt/Lt

Lower Extremity: Functional: Rt/Lt Non-Functional: Rt/Lt

NEUROVASCULAR SIGNS

Sensation to light touch: ☐ Intact ☐ Impaired

Sensation to Pain: ☐ Intact ☐ Impaired

Skin color ________ Skin Temp ________

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Location/Description: ________________

Action taken: ☐ Nurse notified ☐ Other: ________

Additional Comments ______________________

VITALS ☐ Stable per nursing

BP: ______ HR: ______ SPO2: ______ ☐ Supplemental O_2: ______ L/min ☐ Other: ________________

DAILY RECORD

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

(I) ILL
(X) TWICE DAILY
(E) EVALUATION
(NNO) NEED NEW ORDERS
(R) PATIENT REFUSED
(H) HOLIDAY
(RA) REASSESSMENT
(/) ONCE DAILY
(HD) HOLD
(NA) NOT AVAILABLE

PT.

MR.#/RM.

DR.

BALANCE: Sitting ______________________ Standing ______________________

TRANSFERS: Chair/wheelchair to/from bed/mat ______________________

Sit to Stand ______________________ Stand to Sit ______________________

BED MOBILITY: Sit to Supine ______________ Supine to Sit ______________ Rolling ______________

AMBULATION: ______________________

STAIRS: ______________________

WHEELCHAIR MOBILITY/MANAGEMENT: ______________________

EDUCATION:

Patient given written/verbal instructions: ☐ BKA Booklet ☐ AKA Booklet ☐ HEP ☐ ROLE AND GOALS OF PT

☐ Other: ______________________

☐ Safety Precautions Reviewed ______________________

☐ Assistive Device Supplied and Adjusted Device ______________ Supplier ______________

☐ Patient Has Own Assistive Device Device ______________ Assessed by Therapist? ☐ Yes ☐ No

Evaluation of learning: ☐ return demostration ☐ needs review ☐ other: ______________

ASSESSMENT: Potential to Return to PLOF: ☐ Good ☐ Fair ☐ Poor

Barriers to therapy

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Impairments:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Goals: Patient will perform:

☐ Ambulation __________ feet with CG / SBA / INDEP, using walker / quad cane / st. cane / crutches / no device.

☐ Ascend and descend __________ stair steps with CG / SBA / INDEP, using ______________________

☐ Bed Mobility to be CG / SBA / INDEP Other ______________________

☐ Transfers to be CG / SBA / INDEP Other ______________________

☐ Home Exercise Program CG / SBA / INDEP Other ______________________

☐ ______________________

Estimated time frame for goal attainment ______________________

PLAN: Patient will be treated ________x/week until above goals met or acute discharge.

☐ Supply and adjust equipment as necessary

☐ Gait training

☐ Stair training

☐ Transfer training

☐ Bed mobility training

☐ General strengthening

☐ Protocol Exercises

☐ Wheelchair mobility training

☐ Other ______________________

____

Recommendations based on today's evaluation:

☐ Potential to tolerate 3 hours therapy

☐ Discontinue-pt. at baseline/functionally independent

☐ Social work consult for ECF/subacute ______________________

☐ Out-patient physical therapy ______________________

☐ Other: ______________________

Date: ______________ Therapist: ______________________

Time: ______________

Charges: ______________

PT.

MR.#/RM.

DR.