_____, COUNTY HOSPITAL HOME HEALTH
JCAHO/MedicareMedicaid Certified

Physical Therapy Plan Of Care/Treatment

Assessment
Rehab potential for stated goals: ❑ Good ❑ Fair ❑ Poor
❑ Begin PT ❑ Continue PT ❑ Evaluation only ❑ Equipment needs_____
❑ Consult other services _____

Problems:	**Goals:**
1._____	_____resolved within ____ weeks
2._____	_____resolved within ____ weeks
3._____	_____resolved within ____ weeks
4._____	_____resolved within ____ weeks
5._____	_____resolved within ____ weeks
6._____	_____resolved within ____ weeks

Plan
❑ Evaluate this visit, then: ❑ Reassess in _____ weeks ❑ D/C after goals are met
❑ Therapeutic exercises ❑ ↑Strength ❑ ↑Flexibility/ROM ❑ ↑Balance ❑ ↑Coordination/Motor Skills ❑ Muscle Re-ed
❑ Inhibit ❑ Facilitate _____
_____
❑ Establish or upgrade the home exercise program _____
_____
❑ Bed mobility training ❑ Rolling ❑ Scooting ❑ Supine↔Sit _____
❑ Transfer training ❑ Sit↔Stand ❑ Level surface ❑ Unlevel surface ❑ Commode/Shower ❑ Car ❑ Floor↔Stand
❑ Hoyer lift _____
❑ Wheelchair training _____
❑ Gait training Weight bearing____ (R/L) Assistive device: ❑ None ❑ Standard walker ❑ Wheeled walker
❑ Platform walker (R/L) ❑ Hemi-walker ❑ Axillary crutches ❑ Forearm crutches ❑ Large base quad cane
❑ Small base quad cane ❑ Straight cane
❑ Terrain: ❑ Even surface ❑ Uneven surface ❑ Incline/decline ❑ ↑ ↓Steps
_____
❑ Balance activities _____
_____
❑ Modalities _____
❑ Other _____
_____
❑ Vital signs prn _____
❑ **Discharge plan** _____
Frequency and duration of services _____
❑ Orders to be continued into the next recertification period of _____/_____/_____ to _____/_____/_____

Employee Signature: _____ **Date**_____/_____/_____ **Time** _____:_____**AM/PM**

V.O. Physician's Name: _____ **Date POC Returned to HHA:**_____
(Boxed area to be completed by clerical staff)

Physician Signature: _____ **Date:** _____/_____/_____

Patient Name: _____ **Patient ID No.:**_____ **Date:**_____

Make 2 copies. File one copy on the clinical record until signed original is returned from the physician. Send original along with one copy to the physician. Designate the physician's copy by writing. File signed original on the clinical record upon return from the physician.