T.O.N.E
Home Health Services, Inc.
Treating Ongoing Needs Effectively

PHYSICAL THERAPY REVISIT NOTE

VITAL SIGNS: Temperature:__________ Pulse:__________ ❑ Regular ❑ Irregular Respirations:__________ ❑ Regular ❑ Irregular
Blood Pressure: Right______/______ Left______/______ ❑ Lying ❑ Standing ❑ Sitting ❑ O_2 saturation _____% (as ordered)
Pain: ❑ None ❑ Same ❑ Improved ❑ Worse Origin__________________ Location(s)__________________
Duration______________ Intensity 0-10______ Other______________ Relief Measures__________________

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions
❑ Other (specify)__________________________________

TYPE OF VISIT:
❑ Revisit
❑ Revisit and Supervisory Visit
❑ Other (specify) ______________

TREATMENT DIAGNOSIS/PROBLEM AND EXPECTED OUTCOMES__________________________________

PHYSICAL THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X".)

	Evaluation		Gait training		Muscle re-education		Teach safe/effective use of adaptive/assist device (specify)
	Establish/Upgrade home exercise program		Balance training/activities		Management and evaluation of care plan		
	❑ Copy given to patient		TENS		Pulmonary Physical Therapy		Teach safe stair climbing skills
	❑ Copy attached to chart		Ultrasound		Pain Management		Teach fall safety
	Patient/Family education		Electrotherapy		Functional mobility training		Wound care
	Therapeutic exercise		Prosthetic training		Teach bed mobility skills		Other:
	Transfer training		Fabrication of orthotic device		Teach hip safety precautions		

Note: Specify location, amount, frequency and duration with any modality.

ASSESSMENT:__________________________________
ROM:__________________________________
STRENGTH:__________________________________
BALANCE:__________________________________
AMBULATION:__________________________________
Patient/Caregiver Response:__________________________________

SAFETY ISSUES
❑ Obstructed pathways
❑ Home environment
❑ Stairs
❑ Unsteady gait
❑ Verbal cues required
❑ Equipment in poor condition
❑ Bathroom
❑ Commode
❑ Medications__________
❑ Others__________

CARE PLAN: ❑ Reviewed/Revised with patient involvement.
If revised, specify__________________________________
❑ Need for referral (specify)__________________________________

PLAN FOR NEXT VISIT__________________________________

DISCHARGE DISCUSSED WITH: ❑ Patient/Family
❑ Care Manager ❑ Physician ❑ Other (specify) ______________
BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify) ______________

CARE COORDINATION: ❑ Physician ❑ SN ❑ PT/PTA ❑ OT ❑ ST
❑ MSW ❑ Aide ❑ Other (specify) ______________

SUPERVISORY VISIT (Complete if applicable)
❑ PT Assistant ❑ Aide / ❑ Present ❑ Not present
SUPERVISORY VISIT: ❑ Scheduled ❑ Unscheduled
OBSERVATION OF __________________________________
TEACHING/TRAINING OF __________________________________
PATIENT/FAMILY FEEDBACK ON SERVICES/CARE (specify)__________________________________
NEXT SCHEDULED SUPERVISORY VISIT_____/_____/_____
If PT assistant/aide **not present,** specify date he/she was contacted regarding updated care plan:_____/_____/_____

SIGNATURES/DATES

X______________________ _____/_____/_____
Patient/Caregiver (if applicable) *Date*

Complete **TIME OUT** prior to signing below. **Time In**______ **Time Out**______
______________________ _____/_____/_____
Therapist (signature/title) *Date*

PATIENT NAME – Last, First, Middle Initial **ID#**