ADDITIONAL NOTES

SUMMARY

❑ ST Evaluation only. No further indications for service.

❑ Orders for ST evaluation only. Needs additional services, see ST Care Plan.

❑ Need to obtain verbal orders.

❑ Complete orders for ST services with specific treatments, frequency and duration. See ST Care Plan and/or 485.

Instruction provided: ❑ Safety ❑ Exercise ❑ Other (describe)_____

Equipment needed (describe) _____

Patient/Caregiver aware and agreeable to POC: ❑ Yes ❑ No

DISCHARGE DISCUSSED WITH: ❑ Patient/Family
❑ Care Manager ❑ Physician ❑ Other (specify)_____

REFERRAL FOR: ❑ Vision ❑ Hearing ❑ Swallowing
❑ Other (specify) _____

CARE COORDINATION: ❑ Physician ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW
❑ Aide ❑ Other (specify) _____

APPROXIMATE NEXT VISIT DATE_____/_____/_____

PLAN FOR NEXT VISIT_____

PATIENT SIGNATURE (if applicable) _____

THERAPIST'S SIGNATURE/TITLE_____

DATE_____/_____/_____ **TIME IN**_____ **TIME OUT**_____