therapyBOSS Documentation:

Survey-Tested, Agency-Approved.

Home Health Agency
2716 Niles Center Rd
Morton Grove, IL 60053
Phone: 894-856-3654 Fax: 254-936-8364

PHYSICIAN ORDER
EPISODE: 09/25/14 - 11/23/14
11/08/14

PHYSICIAN: Booboo, Brian
PHONE: 312-555-2223
FAX:

PATIENT: Nicepatient, William (#9464653)
DOB: 07/03/1952

Visitation frequency revised as follows:

2x2 added to frequency to address Prehension in bilateral hands, ADL energy conservation and work simplification skills. Message left for doctor on 11/7. 1x1 2x7 new frequency.

SIGNATURES:
COMPLETED AND ELECTRONICALLY SIGNED BY Tanya Goodtherapist, OT

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Home Health Agency
2716 Niles Center Rd
Morton Grove, IL 60053
Phone: 894-856-3654 Fax: 254-936-8364

MISSED VISIT
EPISODE: 10/31/14 - 12/29/14
11/26/14

PHYSICIAN: Sunny, Oscar
PHONE: 815-555-0224
FAX:

PATIENT: Nightengale, Dorothy
DOB: 10/06/1936

Pt ill today. RN saw pt and is aware of pts wt loss loose stools and current state.

SIGNATURES:
COMPLETED AND ELECTRONICALLY SIGNED BY Tanya Goodtherapist, OT

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Home Health Agency
2716 Niles Center Rd
Morton Grove, IL 60053
Phone: 894-856-3654 Fax: 254-936-8364

COMMUNICATION RECORD
EPISODE: 09/30/14 - 11/28/14
10/28/14

PATIENT: Little, Stuart
DOB: 11/23/1952

Spoke to case manager regarding extension of OT services within the current certification period. Case manager agreed, order written.

SIGNATURES:
COMPLETED AND ELECTRONICALLY SIGNED BY Tanya Goodtherapist, OT

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

PHYSICAL THERAPY EVALUATION

EPISODE: 11/09/14 - 01/07/15
11/21/14 2:00PM - 2:45PM 45 MIN

PATIENT: Wanttobebetter, Terrence
DOB: 09/17/1948

Reason for Evaluation ☑ **Initial**
Decline in functional mobility

Homebound Status
- ☑ needs assistance to ambulate
- ☑ leaves home with taxing effort
- ☑ leaves for med appointments only
- ☑ dependent on assistive device
- ☑ residual weakness

Rehabilitation Potential
- ☑ good

Visitation Frequency
1WK1, 2WK3

Pertinent Diagnoses
- ☑ Gait Distrubance
- ☑ Muscle Wasting and Disuse Atrophy

Medical/Surgical/Falls History
Asthma, several falls in past year

Prior Functional Status
Bed mobility: modified independent
Transfers: modified independent
Balance: Good
Ambulation: Ambulation with Rollator, crutches, or straight cane

Vital Signs

BP	TEMP	PULSE (Radial)	PULSE (Apical)	RESP
111/82 (Right arm sitting)		76 (Reg)		18 (Reg)

Pain	Pain Interferes	Pain location	Pain Intensity (0-10)	Frequency
		Right Leg	4	Daily at times

☐ sharp ☐ burning ☑ dull ☐ shooting ☐ cramping ☐ radiating ☐ throbbing ☐ aching

Aggravated by
Prolonged standing

Relieved by
Sitting

Patient Satisfied w/Pain Control: yes

Home Safety
- ☑ No home safety problems

Support System
Housekeeper 5 days a week

Adaptive Equipment
- ☑ wheeled walker
- ☑ crutches
- ☑ cane
- ☑ wheelchair
- ☑ grab bar
- ☑ shower chair

Cognitive Status
- ☑ No problems (oriented x 4)

Muscle Tone
- ☑ Rigidity in LE (R)
- ☑ Rigidity in LE (L)

Sensation

☑ Intact

Proprioception

☑ Reduced in LE (R)

☑ Reduced in LE (L)

Skin Integrity

☑ Intact

Edema

☑ None

Posture

☑ forward head

Dyspnea

☑ SOB after >20 feet walk

Range of Motion and Strength

ROM			Motion	MMT	
Right	**Left**	**Norm**	**Shoulder**	**Right**	**Left**
WFL	WFL	140°	Flexion	3-/5	3-/5
WFL	WFL	50°	Extension	3-/5	3-/5
WFL	WFL	170°	Abduction	3-/5	3-/5
WFL	WFL	0°	Adduction	3-/5	3-/5
WFL	WFL	70°	Internal rotation	3-/5	3-/5
WFL	WFL	90°	External rotation	3-/5	3-/5
Right	**Left**	**Norm**	**Elbow**	**Right**	**Left**
WFL	WFL	145°	Flexion	3-/5	3-/5
WFL	WFL	0°	Extension	3-/5	3-/5
WFL	WFL	80°	Pronation	3-/5	3-/5
WFL	WFL	80°	Supination	3-/5	3-/5
Right	**Left**	**Norm**	**Wrist**	**Right**	**Left**
WFL	WFL	80°	Flexion	3-/5	3-/5
WFL	WFL	70°	Extension	3-/5	3-/5
WFL	WFL	20°	Radial deviation	3-/5	3-/5
WFL	WFL	30°	Ulnar deviation	3-/5	3-/5
Right	**Left**	**Norm**	**Hip**	**Right**	**Left**
WFL	WFL	120°	Flexion	2-/5	2-/5
WFL	WFL	25°	Extension	2-/5	2-/5
WFL	WFL	50°	Abduction	2-/5	2-/5
WFL	WFL	30°	Adduction	2-/5	2-/5
WFL	WFL	45°	Internal rotation	2-/5	2-/5
WFL	WFL	45°	External rotation	2-/5	2-/5
Right	**Left**	**Norm**	**Knee**	**Right**	**Left**
WFL	WFL	135°	Flexion	2-/5	2-/5
WFL	WFL	0°	Extension	2-/5	2-/5
Right	**Left**	**Norm**	**Ankle**	**Right**	**Left**
WFL	WFL	15°	Dorsiflexion	2-/5	2-/5

WFL	WFL	45°	Plantarflexion	2-/5	2-/5
WFL	WFL	35°	Inversion	2-/5	2-/5
WFL	WFL	15°	Eversion	2-/5	2-/5

Bed Mobility

Roll/turn	Modified independent
Sit-to-supine	Modified independent
Supine-to-sit	Modified independent
Scoot/bridge	Modified independent

Transfers

Sit-to-stand	Minimal assist
Stand-to-sit	Minimal assist
In/out of bed	Minimal assist
Chair	Minimal assist

Wheelchair Mobility

Propulsion	Modified independent
Pressure release	Modified independent
Locking breaks	Modified independent
Foot rests	Modified independent

Balance Sitting

Static	Good
Dynamic	Good

Balance Standing

Static	Poor
Dynamic	Poor

Gait

Weight bearing status: Full weight bearing
Aids: cane
Fall risk: high

Level surfaces

Distance/time to break: 5 feet
Assistance: MIN

Deviations

- ☑ lateral trunk lean
- ☑ excessive knee flexion
- ☑ foot slap
- ☑ decreased step length

Physical Therapy Care Plan: New Interventions

1. Therapeutic exercise to develop strength
2. Sit to stand training
3. Standing balance training
4. Gait training
5. Establish home exercise program
6. Provide patient/caregiver in written/or pictoral HEP
7. Pulse oximetry PRN

Physical Therapy Care Plan: New Goals

1. In 4 wks patient will improve strength of R/L LE/UE to 4/5 so he can perform sit to stand transfers with modified independent assist.

2 In 4 wks patient will improve Tinetti score to 22/28 to demonstrate decreased risk for falls

3 In 4 weeks patient will demonstrate the ability to ambulate around the house (150 feet) with assistive device 100% of the with modified independent assist and without loss of balance

4 In 3 wks patient/caregiver will be independent in a HEP.

5 In 4 wks patient will improve sit to stand transfers to modified independent assist.

Discharge Plan

☑ when goals met

☑ independent with HEP and MD follow-up

SIGNATURES:

CARE PLAN DISCUSSED WITH PATIENT/CAREGIVER AND AGREED UPON
EVALUATION DISCUSSED/VERBAL ORDER OBTAINED FROM MD
COMPLETED AND ELECTRONICALLY SIGNED BY Sammy Wonder, PT

PATIENT'S SIGNATURE:

Home Health Agency
2716 Niles Center Rd
Morton Grove, IL 60053
Phone: 894-856-3654 Fax: 254-936-8364

PHYSICAL THERAPY CARE PLAN

EPISODE: 11/09/14 - 01/07/15
11/21/14

PATIENT: Wanttobebetter, Terrence
DOB: 09/17/1948

Reason for Evaluation ☑ **Initial**
Decline in functional mobility

Homebound Status
- ☑ needs assistance to ambulate
- ☑ leaves home with taxing effort
- ☑ leaves for med appointments only
- ☑ dependent on assistive device
- ☑ residual weakness

Rehabilitation Potential
- ☑ good

Visitation Frequency
1WK1, 2WK3

Pertinent Diagnoses
- ☑ Gait Distrubance
- ☑ Muscle Wasting and Disuse Atrophy

Discharge Plan
- ☑ when goals met
- ☑ independent with HEP and MD follow-up

Physical Therapy Interventions
1. Therapeutic exercise to develop strength
2. Sit to stand training
3. Standing balance training
4. Gait training
5. Establish home exercise program
6. Provide patient/caregiver in written/or pictoral HEP
7. Pulse oximetry PRN

Physical Therapy Goals
1. In 4 wks patient will improve strength of R/L LE/UE to 4/5 so he can perform sit to stand transfers with modified independent assist.
2. In 4 wks patient will improve Tinetti score to 22/28 to demonstrate decreased risk for falls
3. In 4 weeks patient will demonstrate the ability to ambulate around the house (150 feet) with assistive device 100% of the with modified independent assist and without loss of balance
4. In 3 wks patient/caregiver will be independent in a HEP.
5. In 4 wks patient will improve sit to stand transfers to modified independent assist.

SIGNATURES:
COMPLETED AND ELECTRONICALLY SIGNED BY Sammy Wonder, PT

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

PHYSICAL THERAPY PROGRESS NOTE

EPISODE: 10/23/14 - 12/21/14
11/05/14 9:00AM - 9:45AM 45 MIN

PATIENT: Oliveretti, Mara
DOB: 02/17/1938

Homebound Status

☑ needs assistance to ambulate
☑ leaves home with taxing effort
☑ dependent on assistive device

Vital Signs

BP	TEMP	PULSE (Radial)	PULSE (Apical)	RESP
143/78 (Right arm sitting)		74 (Reg)		18 (Reg)

Pain

☑ No pain at present

Cognitive Status

☑ No problems (oriented x 4)

Additional Observations

☑ None at this point

Fall Risk Prevention

☑ N/A

Physical Therapy Interventions Performed

	Intervention	Intervention Details
1	Therapeutic exercise to develop strength, flexibility, ROM	Performed and Instructed in standing for 20 reps-mini-squats, wall slides, heel raises, knee bends, marching
2	Sit to stand training	SBA, 20 reps, Instruction provided for proper hand and foot placement
3	Gait training	Gait Training 90 feet with wheeled walker CGA Assist, Instruction provided for upright posture and to increase heel strike

Progress toward Physical Therapy Goals

	Goal	Goal Progress
1	In 7 wks patient will improve strength of R LE strength to 4/5 and R knee flexion to 110 degrees.	R knee ROM -3 to 95 degrees
2	In 7 weeks patient will demonstrate the ability to ambulate to/from apartment and mailbox (200 feet) with assistive device through 100% of the time with modified independent and without loss of balance	90 feet CGA with wheeled walker
3	In 7 wks patient will improve sit to stand transfers to modified independent.	sit to stand at SBA

Physical Therapy Goals Achieved

No newly achieved goals

Instructions

☑ patient
gait pattern

Supervision

☑ N/A

Coordination

☑ None this time

Oliveretti, Mara 11/05/14

Discharge Planning

☑ None this time

Plan for Next Visit

gait training, transfer training,

Visit Code

PT Visit (G0151)

Place of Service

☑ Patient's home/residence

SIGNATURES:

COMPLETED AND ELECTRONICALLY SIGNED BY Sammy Wonder, PT

PATIENT'S SIGNATURE:

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

PHYSICAL THERAPY REASSESSMENT

EPISODE: 10/20/14 - 12/18/14
11/21/14

PHYSICIAN: Douglas, Mariano
PHONE: 630-555-2930
FAX:

PATIENT: Brown, Melissa
DOB: 04/26/1942

Reason for Reassessment ☑ **30-days**

Progress toward Physical Therapy Goals

1	In 5 wks patient will improve strength of R/L LE/UE to 4/5 so he can perform transfers with modified independent assist.	11/21/14 UEs, LEs 3+/5
2	In 5 wks patient will improve Tinetti score to 22/28 to demonstrate decreased risk for falls	11/21/14 Tinetti =21/28
3	In 5 weeks patient will demonstrate the ability to ambulate to/from apartment and mailbox(200 feet) with assistive device or without assistive device 100% of the time independently and without loss of balance	11/21/14 70 feet without AD at CGA 11/19/14 65 feet without AD at CGA 11/14/14 50 feet without AD at min assist/CGA 11/10/14 35 feet without AD at min assist/CGA 11/06/14 25 feet without AD at min assist 11/03/14 Ambulated 25 feet without AD at min assist
4	In 5 wks patient will improve sit to stand transfers to modified independent assist.	11/21/14 sit to stand at CGA/SBA, Demonstrating good carryover of proper hand and foot placement 11/19/14 sit to stand at CGA 11/14/14 sit to stand at Min Assist/CGA 11/10/14 sit to stand at Min Assist 11/06/14 sit to stand at Min Assist 11/03/14 sit to stand at Min Assist 10/28/14 sit to stand at Min Assist

Functional Test Scores

Tinetti	**10/28/14**	**11/21/14**
<19 = High risk of falling, 19 to 24.5 = Increased risk, >24.5 = Low risk	17	21

Reason for Continuing Treatment

☑ patient progressing toward goals with goals attainable in reasonable period of time
To improve ambulation to independent level of assistance

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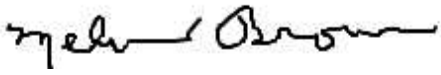
PATIENT'S SIGNATURE: 

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

PHYSICAL THERAPY DISCHARGE SUMMARY

EPISODE: 10/23/14 - 12/21/14
11/19/14

PATIENT: Oliveretti, Mara
DOB: 02/17/1938

Reason for Discharge

☑ outpatient
☑ MD request

Physical Therapy Goals Achieved

1 In 7 wks patient will improve sit to stand transfers to modified independent.

2 In 3 wks patient/caregiver will be independent in a HEP .

Physical Therapy Goals not Achieved

1	In 7 wks patient will improve strength of R LE strength to 4/5 and R knee flexion to 110 degrees.	11/19/14 R knee ROM -1 to 98 degrees, R LE 3+/5 11/17/14 R knee ROM -1 to 96 degrees, R LE 3+/5 11/14/14 R knee ROM -1 to 96 degrees, R LE 3+/5 11/12/14 R knee ROM -3 to 96 degrees 11/10/14 R knee ROM -3 to 96 degrees 11/05/14 R knee ROM -3 to 95 degrees 11/03/14 R knee ROM -3 to 93 degrees 10/31/14 R knee ROM -3 to 93 degrees 10/29/14 R knee ROM -3 to 91 degrees 10/27/14 -8 to 85 degrees
2	In 7 wks patient will improve Tinetti score to 22/28 to demonstrate decreased risk for falls	11/19/14 Tinetti =20/28
3	In 7 weeks patient will demonstrate the ability to ambulate to/from apartment and mailbox (200 feet) with assistive device through 100% of the time with modified independent and without loss of balance	11/19/14 straight cane 150 feet SBA 11/17/14 straight cane 130 feet SBA 11/14/14 straight cane 120 feet SBA 11/12/14 straight cane 100 feet SBA 11/10/14 100 feet CGA/SBA with wheeled walker, Training With straight cane 80 feet CGA 11/05/14 90 feet CGA with wheeled walker 11/03/14 80 feet CGA with wheeled walker 10/31/14 70 feet CGA with wheeled walker 10/29/14 50 feet CGA with wheeled walker

Functional Test Scores

Tinetti	**10/24/14**	**11/19/14**
<19 = High risk of falling, 19 to 24.5 = Increased	19	20

risk, >24.5 = Low risk

Functional Status at Discharge

SBA with ambulation. Modified Independent with ambulation. Independent HEP.

Post Discharge Needs

☑ continue with HEP

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PATIENT'S SIGNATURE: 

Home Health Agency
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OCCUPATIONAL THERAPY EVALUATION

EPISODE: 11/06/14 - 01/04/15
11/07/14 3:20PM - 4:15PM 55 MIN

PHYSICIAN: Coronetti, Natalie
PHONE: 847-555-3077
FAX:

PATIENT: Gettingbetter, Marie
DOB: 10/14/1941

Reason for Evaluation ☑ **Initial**
decline in function

Homebound Status
☑ needs assistance for all activities

Rehabilitation Potential
☑ good

Visitation Frequency
2WK6

Pertinent Diagnoses
☑ weakness

Medical/Surgical/Falls History
dementia muscle weakness HTN recurrent UTI

Prior Functional Status
ADLs: min
Transfers: min

Precautions
falls

Vital Signs

BP	TEMP	PULSE (Radial)	PULSE (Apical)	RESP
136/62 (Right arm sitting)	98.2	68 (Reg)	72 (Reg)	18 (Reg)

Pain
☑ No pain at present

Home Safety
☑ No home safety problems

Support System
☑ No support problems

Adaptive Equipment
☑ wheelchair
☑ commode
☑ grab bar
☑ shower chair

Cognitive Status
☑ impaired judgment
☑ impaired problem solving
☑ Oriented to Person

Muscle Tone
☑ Normal

Sensation
☑ Intact

Proprioception
☑ Reduced in UE (R)
☑ Reduced in UE (L)

Perception

☑ impaired motor planning

Skin Integrity

☑ Impaired

bruising

Edema

☑ non-pitting

☑ LE (L)

Dyspnea

☑ No deficit

Fall Risk

high

Range of Motion and Strength

ROM			Motion	MMT	
Right	**Left**	**Norm**	**Shoulder**	**Right**	**Left**
WFL	WFL	140°	Flexion	3-/5	3-/5
WFL	WFL	50°	Extension	3-/5	3-/5
WFL	WFL	170°	Abduction	3-/5	3-/5
WFL	WFL	0°	Adduction	3-/5	3-/5
WFL	WFL	70°	Internal rotation	3-/5	3-/5
WFL	WFL	90°	External rotation	3-/5	3-/5
Right	**Left**	**Norm**	**Elbow**	**Right**	**Left**
WFL	WFL	145°	Flexion	3-/5	3-/5
WFL	WFL	0°	Extension	3-/5	3-/5
WFL	WFL	80°	Pronation	3-/5	3-/5
WFL	WFL	80°	Supination	3-/5	3-/5
Right	**Left**	**Norm**	**Wrist**	**Right**	**Left**
WFL	WFL	80°	Flexion	3-/5	3-/5
WFL	WFL	70°	Extension	3-/5	3-/5
WFL	WFL	20°	Radial deviation	3-/5	3-/5
WFL	WFL	30°	Ulnar deviation	3-/5	3-/5
Right	**Left**	**Norm**	**Finger**	**Right**	**Left**
WFL	WFL	85°	Flexion	3-/5	3-/5
WFL	WFL	0°	Extension	3-/5	3-/5

Fine Motor

Right	Minimally impaired
Left	Minimally impaired

Gross Motor

Right	Moderately impaired
Left	Moderately impaired

Balance Sitting

Static	Fair+
Dynamic	Fair+

Balance Standing

Static	Fair+
Dynamic	Fair

Transfers

Bed/Wheelchair	Minimal assist
Toilet/Commode	Minimal assist
Tub/Shower	Moderate assist

Self Care Skills

Oral hygiene	Maximum assist
Dressing upper body	Maximum assist
Dressing lower body	Maximum assist
Manipulation of fasteners	Maximum assist
Grooming	Maximum assist
Bathing	Maximum assist
Toileting	Maximum assist
Feeding	Maximum assist

Instrumental ADLs

Meal preparation	Dependent
Housekeeping	Dependent
Telephone use	Dependent
Medication management	Dependent

Occupational Therapy Care Plan: New Interventions

1 Establish and instruct patient/caregiver in a Home Exercise Program
2 Work simplification training
3 Energy conservation training
4 UB Dressing training (pull over shirts, button up shirts, undergarments, fasteners)
5 LB Dressing training (pants, shoes, socks, undergarments)

Occupational Therapy Care Plan: New Goals

1 Patient/caregiver will verbalize/demonstrate their understanding of HEP for BUEs within 6 weeks
2 Patient will increase strength in B UE to 4/5 to allow for min assist in performing ADLs within 6 weeks
3 Patient's ability to groom self will increase as evidenced by S level of assist within 6 weeks

Discharge Plan

☑ when max rehab potential reached

SIGNATURES:

CARE PLAN DISCUSSED WITH PATIENT/CAREGIVER AND AGREED UPON
EVALUATION DISCUSSED/VERBAL ORDER OBTAINED FROM MD
COMPLETED AND ELECTRONICALLY SIGNED BY Tanya Goodtherapist, OT

PATIENT'S SIGNATURE:

PHYSICIAN'S SIGNATURE: _____ DATE: _____

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2716 Niles Center Rd
Morton Grove, IL 60053
Phone: 894-856-3654 Fax: 254-936-8364

OCCUPATIONAL THERAPY CARE PLAN

EPISODE: 11/06/14 - 01/04/15
11/07/14

PHYSICIAN: Coronetti, Natalie
PHONE: 847-555-3077
FAX:

PATIENT: Gettingbetter, Marie
DOB: 10/14/1941

Reason for Evaluation ☑ **Initial**
decline in function

Homebound Status
☑ needs assistance for all activities

Rehabilitation Potential
☑ good

Visitation Frequency
2WK6

Pertinent Diagnoses
☑ weakness

Discharge Plan
☑ when max rehab potential reached

Occupational Therapy Interventions
1 Establish and instruct patient/caregiver in a Home Exercise Program
2 Work simplification training
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5 LB Dressing training (pants, shoes, socks, undergarments)

Occupational Therapy Goals
1 Patient/caregiver will verbalize/demonstrate their understanding of HEP for BUEs within 6 weeks
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3 Patient's ability to groom self will increase as evidenced by S level of assist within 6 weeks

SIGNATURES:
COMPLETED AND ELECTRONICALLY SIGNED BY Tanya Goodtherapist, OT

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

OCCUPATIONAL THERAPY PROGRESS NOTE

EPISODE: 11/06/14 - 01/04/15
11/21/14 8:51AM - 9:36AM 45 MIN

PATIENT: Gettingbetter, Marie
DOB: 10/14/1941

Homebound Status

☑ needs assistance for all activities

Vital Signs

BP	TEMP	PULSE (Radial)	PULSE (Apical)	RESP
124/83 (Right arm sitting)	97.5	68 (Reg)	70 (Reg)	18 (Reg)

Pain

☑ No pain at present

Cognitive Status

☑ impaired judgment
☑ impaired problem solving
☑ Oriented to Person

Additional Observations

☑ None at this point

Fall Risk Prevention

☑ fall precautions maintained

Occupational Therapy Interventions Performed

	Intervention	Intervention Details
1	Establish and instruct patient/caregiver in a Home Exercise Program	
2	Work simplification training	
3	Energy conservation training	
4	UB Dressing training (pull over shirts, button up shirts, undergarments, fasteners)	
5	LB Dressing training (pants, shoes, socks, undergarments)	

Progress toward Occupational Therapy Goals

	Goal	Goal Progress
1	Patient/caregiver will verbalize/demonstrate their understanding of HEP for BUEs within 6 weeks	HEP practiced woth min assist
2	Patient's ability to groom self will increase as evidenced by S level of assist within 6 weeks	Grooming with set up and mod assist seated bedside. Dressing UB with min assist to pull shirt down. Safety training with mod assist

Occupational Therapy Goals Achieved

No newly achieved goals

Instructions

☑ patient
☑ caregiver

HEP

Supervision

☑ N/A

Coordination

☑ None this time

Discharge Planning

☑ None this time

Plan for Next Visit

Ther ex ADLs

Visit Code

OT Visit (G0152)

Place of Service

☑ Patient's home/residence

SIGNATURES:

COMPLETED AND ELECTRONICALLY SIGNED BY Tanya Goodtherapist, OT

PATIENT'S SIGNATURE:

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

OCCUPATIONAL THERAPY REASSESSMENT

EPISODE: 06/13/14 - 08/11/14
07/15/14

PHYSICIAN: Allen, Kenneth
PHONE: 630-555-0164
FAX:

PATIENT: Fellill, Macy
DOB: 03/25/1938

Reason for Reassessment ☑ **30-days**

Progress toward Occupational Therapy Goals

1	Patient/caregiver will verbalize/demonstrate their understanding of HEP for BUEs within 6 weeks	07/15/14 HEP practiced with mod assist 07/14/14 HEP practiced with mod assist 07/08/14 HEP with min assist 07/02/14 HEP completed with mod assist 06/30/14 pt needs mod assist to complete HEP 06/27/14 HEP practiced with mod assist 06/25/14 HEP practiced with min assist 06/18/14 HEP practiced with min assist 06/16/14 Initiated
2	Patient will increase strength in BUE to 3+/5 to allow for mi assist in performing ADLs within 6 weeks	07/15/14 Patient requires encouragement but will complete exs with OT. Theraband exs x 20 x 2 sets completed with min assist and cues. Grooming and hyg x 10 min with mod assist 07/14/14 Encouragement needed to perform ther exs. Groomjng and hyg at sink with cues and mod assist to complete following energy conservation and work simplification techniques. 07/08/14 BUE theraband exs x 20 x 2 sets. ADL grooming and hyg with mod assist to follow energy conservation and work simplification techniques 07/02/14 Theraband exs x 20 x 2 sets all UE planes. Therapeutic exs with dowel x 10 flexion and extension of shoulder. ADL grooming and hyg x 20 min practicing energy conservation and work simplification techniques 06/30/14 encouragement needed to perform ADL grooming and hyg and mod assist to follow safety and energy conservation techniques. Pt does best in a quiet non distracting environment 06/27/14 Pt continues to need encouragement to participate in activities, but will engage esp when humor is used. Theraband exs x 20 x 2 steps. ADL retraining grooming and hygiene

with energy conservation and work simplification techniques practiced with mod assist
06/25/14
Pt needs encouragement to complete ADLs and to engage in therapy. Theraband exs x20 x 2 sets. ADL grooming and hygiene with mod assist to follow energy conservation and work simplification techniques.
06/18/14
Theraband ex with encouragement BUEs yellow band x20 x2sets. MFR and massage to BUE shoulders x 20"minutes. Therapeutic table top activity x 20 min involving fine motor prehension. Patient needs encouragement to participate fully
06/16/14
Initiated

Functional Test Scores

Katz ADL	**06/16/14**
6 = Patient is independent, 0 = Patient is very dependent	1

Reason for Continuing Treatment

☑ patient progressing toward goals with goals attainable in reasonable period of time
Pt is mking steady slow progress

COMPLETED AND ELECTRONICALLY SIGNED BY Tanya Goodtherapist, OT

PATIENT'S SIGNATURE:

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

OCCUPATIONAL THERAPY DISCHARGE SUMMARY

EPISODE: 09/10/14 - 11/08/14
11/06/14

PHYSICIAN: Baker, Dr.
PHONE: 847-837-8442
FAX:

PATIENT: Inrecovery, Deborah
DOB: 03/08/1938

Reason for Discharge

Goals met and plateau in other goals

Occupational Therapy Goals Achieved

1 Patient/caregiver will verbalize/demonstrate their understanding of HEP for R UE within 3 weeks

2 Patient will increase strength in R UE to 3/5 to allow for set up assist in performing ADLs within 8 weeks

3 Patient will be at supervision assist in transferring in/out of bath/shower using grab bar/commode for assistance to allow for good hygiene within 8 weeks

4 Patient will be knowledgeable in fall prevention and safety techniques within 4 weeks

Occupational Therapy Goals not Achieved

1	Standing balance will improve to SBA in order for patient to be able to pull up pants after toileting within 5 weeks	11/06/14 met 10/30/14 Toileting skills including safety during transfer, energy conservation and clothing management 09/25/14 Pt requires Min A for balance, as well as cues for safe hand placement while pulling pants over hips during toileting
2	Patient will improve standing static/dynamic balance to SBA for increased independence with homemaking tasks within 4 weeks	10/14/14 Pt stood sink side for grooming ADLs visual reminder to use both hands. Min assist for ther exs seated in straight back chair.
3	Patient will increase attention to task to 5 minutes to demonstrate increased independence with leisure activities/ipad within 5 weeks	10/03/14 Distraction free environment to practice following simple commands to access her aug comm device for communication.
4	Patient will increase dexterity of R hand/fingers to allow for independence (mod ind) in using buttons or zippers on clothing within 8 weeks	10/28/14 pt practiced zippers boig 2 inch buttons and snaps x 10 each with min assist 09/25/14 Pt participated in R coordination exercises (thumb to finger opposition, hand exercises, reach and grasping/release) with Mod cues for sequencing and thoroughness
5	Patient will properly lock brakes within 4 weeks	09/25/14 Pt required frequent cues to lock breaks prior to standing
6	Patient's will demonstrate significant signs of increased endurance as evidenced by standing at the sink/counter for 5 minutes within 5 weeks	

Functional Test Scores

Barthel Index	**09/25/14**

<20 = Completely dependent, 20-39 = Very dependent, 40-59 = Partially dependent, 60-79 = Needs minimal help with ADL, 80-100 = Mostly independent	65

Functional Status at Discharge

Pt can follow HEP with MI

Post Discharge Needs

☑ continue with HEP

Use Assistive tech device

COMPLETED AND ELECTRONICALLY SIGNED BY Tanya Goodtherapist, OT

PATIENT'S SIGNATURE:

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

SPEECH THERAPY EVALUATION

EPISODE: 07/29/14 - 09/26/14
08/15/14 2:00PM - 3:00PM 60 MIN

PATIENT: Improving, Rose
DOB: 05/08/1943

Reason for Evaluation ☑ **Initial**

Per family report, pt. having increasing difficulties with swallowing.

Homebound Status

☑ needs assistance for all activities

Rehabilitation Potential

☑ fair

Pt. cooperative and motivated with good support, but has severe, degenerative weakness.

Visitation Frequency

1WK1, 2WK3

Pertinent Diagnoses

☑ Parkinson's Disease (early)

Medical/Surgical History/Previous Speech Therapy Treatment

Son states that pt. began demonstrating signs of dementia in 2012, as well as poor circulation, for which she received several procedures to restore circulation. Son also stated that pt.'s swallowing has deteriorated over the past few weeks and her speech is unintelligible at times, although it becomes more intelligible the longer she talks. Did not report any past ST. Pt. and CG state that she has never received therapy for any reason.

Prior Functional Status

Cognition: Per son, signs of dementia began in 2012.
Expression: Moderate, due to frequent unintelligibility.
Comprehension: WFL
Swallowing: WFL

Precautions

Pt. a fall risk - requires 24/7 assistance.

Vital Signs

BP	TEMP	PULSE (Radial)	PULSE (Apical)	RESP
122/77 (Left arm sitting)		78 (Reg)		

Physical Status

Pt. is not ambulatory - requires assist. to be removed from bed.

Pain	Pain Interferes	Pain location	Pain Intensity (0-10)	Frequency
		ankle/foot	10	Daily at times

☐ sharp ☐ burning ☐ dull ☐ shooting ☐ cramping ☐ radiating ☐ throbbing ☑ aching

Aggravated by
n/a

Relieved by
pain killers

Patient Satisfied w/Pain Control: no

Pt. unable to specify quality of pain.

Support System

☑ No support problems

Cognitive Status

☑ memory deficit
☑ impaired judgment
☑ Oriented to Person
☑ Oriented to Place

Pt. was able to state location given two choices. Stated that she did not know the year or month and that she thought the season was Fall. Repeatedly asked why clinician was there and "what's it all for?"

Diet

☑ risk of aspiration
☑ soft solids
☑ thickened liquids

Recommend honey thick liquids, no food with small pieces or particles, remind pt. to clear throat frequently, monitor for oral residue and cue pt. to clear residue. Liquid wash beneficial for clearing residue.

Additional Comments

Pt. c/o ankle being "very painful" and asked for help with the pain. Pt. presents with mod-severe flaccid dysarthria and mod-severe oropharyngeal dysphagia. Not a good candidate for VFSS due to age and decreased alertness/response time. Pt. tongue crusted over and CG reports that she is orally defensive and will not allow a toothbrush past her front teeth.

Expressive Language		
Simple sentences	Moderately impaired	Frequently unintelligible.
Complex sentences	Severely impaired	Pt. unable to maintain breath support for more than simple phrases.
Repetition	Within functional limits	Although pt. required one breath per two words on all sentences.
Conversation	Moderately impaired	Pt. frequently unintelligible and out of breath.

Auditory Comprehension	
Word discrimination	Within functional limits
1-step directions	Within functional limits
2-step directions	Within functional limits
Complex directions	Within functional limits
Conversation interaction	Within functional limits
Speech reading	Within functional limits

Speech/Voice		
Articulation	Severely impaired	Pt. muscles extremely weak and speech largely unintelligible.
Prosody	Moderately impaired	Pt. mostly monotone with frequent phrase breaks due to SOB.
Speech intelligibility	Severely impaired	Very difficult to understand pt. speech.
Voice	Moderately impaired	Mildly reduced intensity with very short phrases per breath.
Respiration	Severely impaired	Pt. unable to say more than three words per breath.
Resonance	Moderately impaired	Hypernasal

Swallowing		
Liquids	Moderately impaired	Mod-severe - trials of thin coffee and nectar thick water resulted in anterior spillage, repeated throat clear, and watery vocal quality; "chewed" water and coffee.
Solids	Moderately impaired	Trials of bread: prolonged mastication and oral transit, oral residue present, multiple swallows per bolus, repeated throat clear while chewing, talking while chewing.
Chewing ability	Moderately impaired	Pt. chews all textures, including liquid, at the front of the mouth with an open mouth posture, resulting in anterior spillage.
Oral phase	Moderately impaired	Prolonged mastication (5+ seconds) of solids, also chews liquids and purees, holds textures in mouth for up to 5 seconds before manipulating them.
Pharyngeal phase	Moderately impaired	Delayed swallow response (up to 5 seconds), reduced laryngeal elevation, suspected residue based on watery vocal quality and repeated throat clearing following all trials.
Reflex time	Moderately impaired	Delay up to 5 seconds on all consistencies.

Speech Therapy Care Plan: New Interventions

1 Instruct safe PO with current diet to prevent signs and symptoms of aspiration.

2 Instruct in BOT/OM exercises to increase labial and lingual skills for speech and swallowing.

3 Instruct methods to improve/restore speech intelligibility to increase independence in communication and decrease frustration.

Improving, Rose 08/15/14

Speech Therapy Care Plan: New Goals

1 Pt. will demonstrate safe PO with current diet with 80% accuracy without signs and symptoms of aspiration with mod assist within 4 weeks.

2 Pt. will produce words and phrases demonstrating 80% intelligibility using exaggerated articulation within 4 weeks.

3 Pt. will sustain /a/ for avg of 5 seconds 5 times per session.

4 Pt. will improve breath support in order to produce 5 words per breath 5 times per session within 4 weeks.

5 Pt. will participate in velopharyngeal strengthening exercises with 80% accuracy by Week 4.

Discharge Plan

☑ when max rehab potential reached

SIGNATURES:

CARE PLAN DISCUSSED WITH PATIENT/CAREGIVER AND AGREED UPON
EVALUATION DISCUSSED/VERBAL ORDER OBTAINED FROM MD
COMPLETED AND ELECTRONICALLY SIGNED BY Deana Speech, SLP

PATIENT'S SIGNATURE:

Improving, Rose 08/15/14

Home Health Agency
2716 Niles Center Rd
Morton Grove, IL 60053
Phone: 894-856-3654 Fax: 254-936-8364

SPEECH THERAPY CARE PLAN

EPISODE: 07/29/14 - 09/26/14
08/15/14

PATIENT: Improving, Rose
DOB: 05/08/1943

Reason for Evaluation ☑ **Initial**
Per family report, pt. having increasing difficulties with swallowing.

Homebound Status
☑ needs assistance for all activities

Rehabilitation Potential
☑ fair
Pt. cooperative and motivated with good support, but has severe, degenerative weakness.

Visitation Frequency
1WK1, 2WK3

Pertinent Diagnoses
☑ Parkinson's Disease (early)

Discharge Plan
☑ when max rehab potential reached

Speech Therapy Interventions
1 Instruct safe PO with current diet to prevent signs and symptoms of aspiration.
2 Instruct in BOT/OM exercises to increase labial and lingual skills for speech and swallowing.
3 Instruct methods to improve/restore speech intelligibility to increase independence in communication and decrease frustration.

Speech Therapy Goals
1 Pt. will demonstrate safe PO with current diet with 80% accuracy without signs and symptoms of aspiration with mod assist within 4 weeks.
2 Pt. will produce words and phrases demonstrating 80% intelligibility using exaggerated articulation within 4 weeks.
3 Pt. will sustain /a/ for avg of 5 seconds 5 times per session.
4 Pt. will improve breath support in order to produce 5 words per breath 5 times per session within 4 weeks.
5 Pt. will participate in velopharyngeal strengthening exercises with 80% accuracy by Week 4.

SIGNATURES:
COMPLETED AND ELECTRONICALLY SIGNED BY Deana Speech, SLP

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

SPEECH THERAPY PROGRESS NOTE

EPISODE: 07/29/14 - 09/26/14
09/03/14 10:43AM - 11:43AM 60 MIN

PATIENT: Progressing, Colleen
DOB: 01/14/1937

Homebound Status

☑ needs assistance for all activities

Vital Signs

BP	TEMP	PULSE (Radial)	PULSE (Apical)	RESP
104/61 (Left arm sitting)		86 (Reg)		

Pain	Pain Interferes	Pain location	Pain Intensity (0-10)	Frequency
		foot	5	All of the time

☐ sharp ☐ burning ☐ dull ☐ shooting ☐ cramping ☐ radiating ☐ throbbing ☑ aching

Aggravated by
nothing - pt not ambulatory

Relieved by
pain killers

Patient Satisfied w/Pain Control: no

Cognitive Status

☑ memory deficit
☑ impaired judgment
☑ Oriented to Person

Pt. unable to state anything other than her name.

Additional Observations

Pt. was awake when clinician arrived, just finishing a sponge bath. Appeared to be in good spirits and was pleased to greet clinician today.

Speech Therapy Interventions Performed

	Intervention	Intervention Details
1	Instruct patient in BOT/OM exercises to increase labial and lingual skills for speech and swallowing.	
2	Instruct methods to promote increased phrases intelligibility/intensity.	

Progress toward Speech Therapy Goals

	Goal	Goal Progress
1	Pt. will complete BOT/OM exercises 10 times with 80% accuracy each to increase labial and lingual skills for speech and swallowing, independently within 3 weeks.	Tongue front=88% acc, L-R=100% acc, tongue elevation=67% acc, move frozen lemon glycerin swab L-R and R-L 38%. Pt. orally defensive when tongue touched in center - appears to have a mild tongue thrust reflex.
2	Pt. will sustain /a/ for avg of 5 seconds 5 times per session.	Pt. sustained /a/ average of 3.1 seconds 15x.

Speech Therapy Goals Achieved

No newly achieved goals

Patient/Caregiver Response Additional Comments

Pt. was cooperative, seated upright in bed. Alertness level decreased as session progressed - pt. was asleep by end of session. Verbal cues beneficial for improving performance on tasks. CG reports that pt. ate well this morning but had a bad night last night. CG reported that pt. occasionally gags while eating, consistent with oral defensiveness and tongue thrust reflex.

Instructions

☑ patient
☑ caregiver

Cue for chin tuck with each swallow. Clear throat and reswallow after each bite. Liquid wash following bites of solids. Maintain good oral care to reduce risk of aspiration pneumonia. Use frozen lemon swabs to practice bolus manipulation every day. Also practice tongue protrusions front, left, right, and elevation.

Supervision
☑ N/A

Coordination
☑ HH Aide

Discharge Planning
☑ discussed expected date of D/C
☑ discussed assessed progress

Plan for Next Visit
Continue POC.

Visit Code
ST Visit (G0153)

Place of Service
☑ Assisted living facility

SIGNATURES:
COMPLETED AND ELECTRONICALLY SIGNED BY Deana Speech, SLP

PATIENT'S SIGNATURE:

Home Health Agency
Phone: 894-856-3654
Fax: 254-936-8364

SPEECH THERAPY DISCHARGE SUMMARY

EPISODE: 07/29/14 - 09/26/14
09/06/14

PATIENT: Improving, Rose
DOB: 05/08/1943

Reason for Discharge

☑ lack of progress

Pt. ability to participate in tx is variable based on her cognitive status that day and clinician has been unable to establish a consistent therapy routine. HH aide also reported not being able to do home exercises consistently. Pt. is able to swallow safely with modified diet and using compensatory strategies with maximum cueing (HH aide must cue her to bow her head with every swallow and to reswallow after clearing her throat).

Speech Therapy Goals Achieved

1 Pt. will complete BOT/OM exercises 10 times with 80% accuracy each to increase labial and lingual skills for speech and swallowing, independently within 3 weeks.

2 Pt. will demonstrate safe PO with current diet with 80% accuracy without signs and symptoms of aspiration with mod assist within 4 weeks.

Speech Therapy Goals <u>not</u> Achieved

1	Pt. will produce words and phrases demonstrating 80% intelligibility using exaggerated articulation within 4 weeks.	09/06/14 Pt. unable to use exaggerated articulation due to extreme muscle spasticity.
2	Pt. will sustain /a/ for avg of 5 seconds 5 times per session.	09/06/14 Pt. was able to sustain /a/ for average of 2.85 seconds 10x today. 09/03/14 Pt. sustained /a/ average of 3.1 seconds 15x. 08/29/14 Pt. was able to sustain /a/ for average of 2.3 seconds 10x today. Longest sustain = 3.5 sec, shortest = 1.5 sec. 08/22/14 Pt. able to sustain /a/ avg of 2.5 sec 10x. 08/20/14 Pt. was able to sustain /a/ for avg of 2.6 sec. across 10 trials. When changed to /o/, pt. was able to sustain for avg of 2.35 sec. across 10 trials. 08/15/14 Goal not met - pt. sustained /a/ for avg of 2 seconds across 3 trials.
3	Pt. will improve breath support in order to produce 5 words per breath 5 times per session within 4 weeks.	09/06/14 Pt. was able to produce 2-3 words per breath 5 times. 08/20/14 Pt. was able to produce 4 words in one breath 5/10x (50%). She was able to produce 3 words per breath 3/10x. 08/15/14 Goal not met - pt. produced 2 words per breath across 5 trials.
4	Pt. will participate in velopharyngeal strengthening exercises with 80% accuracy by Week 4.	09/06/14 Pt. unable to perform any velopharyngeal exercises due to extreme velopharyngeal incompetence. 08/20/14 Pt. was unable to perform velopharyngeal exercises (blowing through straw, blowing bubbles) in any context.

Functional Status at Discharge

Pt. continues with severe spastic dysarthria and moderate oropharyngeal dysphagia characterized by oral defensiveness, prolonged oral prep and oral transit, oral residue, velopharyngeal insufficiency, pharyngeal swallow delay, and pharyngeal residue. Pt. aspirates thin liquids and aspirates nectar thick liquids unless using a chin tuck maneuver. With honey thick liquids and purees/soft solids, pt. is able to swallow without s/s of aspiration when cued to tuck chin and to clear throat of pharyngeal residue regularly. Liquid wash is beneficial for clearing residue as well.

Post Discharge Needs

☑ continue with HEP

Excellent oral hygiene continues to be essential to prevent aspiration pneumonia.

COMPLETED AND ELECTRONICALLY SIGNED BY Regina Bestslp, SLP

PATIENT'S SIGNATURE:

Improving, Rose 09/06/14