Physical Therapy Treatment Report:
Guidelines for the usage of this form are as follows:

PART I

1. Basic information is entered as indicated on the form including patient's name, MPI#, Division, and Unit.

2. Treating Diagnosis/ Chief Complaint - indicate the reason for referral.

3. Patient Problem Statement – the patient's reason for Physical Therapy. Respond with "unable to answer", if the patient is not able to answer questions.

4. Treatment – Physical Therapy interventions that the patient has received since the last treatment report.

5. Treatment Schedule – Time, dates and frequency of scheduled Physical Therapy treatment. Also note location of treatment, if appropriate.

6. Proposed Discharge Plan – Location and type of facility that the patient is expected to be discharge to from CVH, if known. If this is not known, i.e. pending court decision, document as such.

7. Interpreting Services Required – Note if the patient requires interpreting services and which language is the patient's language of choice.

8. Date of Last Physical Therapy Evaluation – Date of the most recent evaluation (annual, change in status or condition or initial assessment).

9. The evaluating therapist signs, prints name and title and dates the report form.

PART II – Treatment Rendered

1. First and fourth columns – Day of the month.

2. Second and fifth columns – Code as noted at the bottom of the page describing if treatment was given or why treatment was not given.

3. Third and sixth columns – Comments concerning treatment given.

PART III – Treatment Report

1. Summary of Treatment Received – Overview of all treatment received since last report. In addition, progression of treatment since last report should be noted here. For example, note the increased time walking or usage of a different assistive device.

2. Educational Issues Addressed – Educational issues associated with Physical Therapy Treatment discussed with patient and staff involved with the patient's care. Note if written materials were given to patient or staff. Also, patient's response and level of understanding of material presented.

3. Functional Assessment – Patient's present level of functioning noting changes since last report.

4. Communication Issues – Document if the patient has receptive or expressive communication issues that may interfere with their understanding of the educational material being presented.

5. Treatment Program Changes/ Recommendations/ Frequency of Treatment - Changes to Physical Therapy Program which will be made for the following month. Recommendations for activities to be encouraged or discouraged concerning the patient's physical condition for which they are receiving Physical Therapy. For example, a patient who recently fractured an ankle may be non-weight bearing on that leg. Note here when and how often Physical Therapy treatment is proposed in the upcoming month.

6. Review of Goals of Physical Therapy Treatment – Goals of Physical Therapy that the patient will be working towards in the following month. Goals should be measurable and functional in nature.

7. Assessment and Treatment Plan discussed with Patient – Indicate yes or no. If no, Write explanation of why the report form was not discussed with patient.

10. The evaluating therapist signs, prints name and title and dates the report form.