



GEM STAFFING

Patient Name:	SOC:	
Record #:	Date:	Time In : _____ Time Out : _____

PHYSICAL THERAPY EVALUATION

<input type="checkbox"/> Initial	<input type="checkbox"/> Interim	<input type="checkbox"/> Discharge	Condition at DC <input type="checkbox"/> Improved <input type="checkbox"/> Plateaued <input type="checkbox"/> No Change <input type="checkbox"/> Regressed
Dr. _____ notified of assessment and verbal orders received			

PT FOR: <input type="checkbox"/> EVAL & RX (B1) <input type="checkbox"/> THER EX/ROM (B2) <input type="checkbox"/> TRANSFER TRAIN (B3) <input type="checkbox"/> GAIT TRAIN (B8) <input type="checkbox"/> CHEST PT <input type="checkbox"/> ULTRASOUND <input type="checkbox"/> ELECTROTHERAPY <input type="checkbox"/> PROSTHETIC (B9) <input type="checkbox"/> HOME EX PROGRAM (B4) <input type="checkbox"/> OTHER (B15)	FUNCTIONAL LIMITATIONS <input type="checkbox"/> GAIT <input type="checkbox"/> TRANSFERS <input type="checkbox"/> STAIRS <input type="checkbox"/> ADL <input type="checkbox"/> COGNITION <input type="checkbox"/> ENDURANCE <input type="checkbox"/> OTHER _____	REASON FOR D/C <input type="checkbox"/> MAX POTENTIAL ACHIEVED <input type="checkbox"/> EXPIRED <input type="checkbox"/> REFUSED SERVICE <input type="checkbox"/> MOVED <input type="checkbox"/> ADMITTED TO INSTITUTION <input type="checkbox"/> MD REQUEST <input type="checkbox"/> ANOTHER AGENCY/ HOSPICE <input type="checkbox"/> OTHER _____	DISPOSITION CODE <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL <input type="checkbox"/> PSYCHIATRIC HOSPITAL <input type="checkbox"/> DISABILITY CENTER <input type="checkbox"/> RESIDENTIAL FACILITY <input type="checkbox"/> ALT CARE PROGRAM <input type="checkbox"/> HOSPICE <input type="checkbox"/> DEATH <input type="checkbox"/> OTHER _____
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ORDERED FREQUENCY/ DURATION _____ OT RECOMMENDED: yes / no MD CHANGE ORDER WRITTEN FOR OT: YES ___ NO ___ GOALS : See attached goal sheet	DISCHARGE TO (check one) <input type="checkbox"/> INDEPENDENT <input type="checkbox"/> CAREGIVER <input type="checkbox"/> LTC FACILITY <input type="checkbox"/> PT CARE FOR UNTIL EXPIRES	MD INFORMED OF D/C: YES ___ DOES MD WANT COPY OF THE D/C SUMMARY: YES ___ NO ___
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MEDICAL and TREATMENT DIAGNOSIS: Primary Dx (PT related): Surgical Procedure: Other Dx:	HOME SAFETY: ___ ASPEN COMPLETED ___ WRITTEN HEP SUBMITTED ___ BERG BALANCE ___ TINETTI ___ DGI
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P.O.T., RISKS, ALTERNATIVES, BENEFITS OF CARE REVIEWED WITH THE:
 _____ PATIENT ___ FAMILY CAREGIVER ___ OTHER _____

REHAB POTENTIAL: ___ Excellent ___ Good ___ Fair ___ Guarded ___ Poor

B/P	PULSE	RR	TEMP
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MENTAL STATUS (circle if impaired):
 ORIENTATION/ ATTENTION SPAN/ MOTIVATION/ MEMORY/ FOLLOW DIRECTION/ JUDGEMENT

PATIENT'S CONCERNS:

PATIENT'S GOALS:

PRIOR FUNCTIONAL STATUS

HOME ASSESSMENT/ EQUIPMENT SAFETY

Check appropriately:

STATIC SITTING BALANCE
 G ___ G- ___ F + ___ F ___ F- ___ P + ___ P ___ P- ___

DYNAMIC SITTING BALANCE
 G ___ G- ___ F + ___ F ___ F- ___ P + ___ P ___ P- ___

STATIC STANDING BALANCE
 G ___ G- ___ F + ___ F ___ F- ___ P + ___ P ___ P- ___

DYNAMIC STANDING BALANCE
 G ___ G- ___ F + ___ F ___ F- ___ P + ___ P ___ P- ___

Check appropriately:
 SITTING POSTURE/ STANDING POSTURE/ COORDINATION/ SENSORY/ TONE

HISTORY OF FALL: YES / NO | SCORES: TINETTI ___ BERG ___ DGI _____

FALL RISK: ___ HIGH ___ MEDIUM ___ LOW | DESCRIBE:

SKIN/ EDEMA:

ROM MUSCLE STRENGTH/ DEFICIT	PAIN (0-10) LOCATION
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HOW RELIEVED:



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FUNCTIONAL ASSESSMENT KEY E=EVAL G=GOAL D=DISCHARGE

7 = INDEPENDENT 6 = INDEPENDENT SLOW 5= SUPERVISION 4 = MINIMAL ASSIST 3= MODERATE ASSIST 2 = MAXIMUM ASSIST

1 = INDEPENDENT NT = NOT TESTED NA = NOT APPLICABLE

B3 TRANSFER SKILLS	E	G	D	B3 TRANSFER SKILLS	E	G	D	B3 GAIT SKILL	E	G	D	B3 PROSTHETIC SKILL	E	G	D	B5 GAIT TRAINING	E	G	D
ROLLING R __ L __				LATERAL TRANSFER				WALKER				DONNING/ DOFF				LEVEL			
BRIDGING/ SCOOTING				TUB/SHOWER				CRUTCHES				STUMP CARE				NON-LEVEL			
SUPINE/ SIT SUPINE				FLOOR UP & DOWN				QUAD CANE				ORTHOTICS				RAMP			
SIT-STAND-SIT (Bed-Chair-Toilet)				W/C MANAGEMENT												CARPET			
NONAMBULATORY				IN & OUT CAR				NO DEVICE				GAIT TRAINING DISTANCE & TIME <input type="checkbox"/> NWB <input type="checkbox"/> PWB <input type="checkbox"/> FWB <input type="checkbox"/> WBAT <input type="checkbox"/> TTWB							
GAIT DEVIATIONS	E	G	D	GAIT DEVIATIONS	E	G	D	GAIT DEVIATIONS	E	G	D	GAIT DEVIATIONS	E	G	D				
STEP TO TOE IN TOE OUT ∨ HEEL STRIKE UNEVEN STRIDE				SHORT STRIDE NARROW BOS WIDE BOS SCISSORING ATAXIA				TRENDELENBERG CIRCUMDUCTION SHUFFLING FESTINATING ANTALGIC				HIGH STEPPAGE ∨ PUSH OFF FOOT DRAG BENT POSTURE SWING							

SKILLED INTERVENTION

B4 HOME PROGRAM/ TRAINING INSTRUCTED:

IN: THER X SAFETY PATIENT MOBILITY FAMILY/CAREGIVER BALANCE OTHER TRANSFERS

AMBULATION SKILLS

INSTRUCTIONS: WRITTEN VERBAL VISUAL FORMAT

RESPONSE: CAN FULLY PARTIALLY UTILIZE INSTRUCTIONS

RETURN DEMONSTRATIONS GIVEN: YES NO PARTIALLY

BARRIERS TO GOAL STRUCTURAL CAREGIVER PSYCHOSOCIAL COMPLIANCE

MEDICAL CONDITION OTHER _____

PLAN: CONTINUE AT _____ FREQUENCY _____ WEEKS

CONFERENCE WITH : MD __ RN __ PT __ PTA __ OT __ OTA __ ST __ MSW __ HHA __ CASE MANAGER __ DME __ OTHER __

CONTENT OF CONFERENCE:

PHYSICIAN'S NAME	PATIENT'S SIGNATURE:
EVALUATED BY/ SIGNATURE/ TITLE/ DATE	



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REHABILITATION GOALS



PT

PATIENT

PROJECTED NUMBER OF VISITS:

Home Bound 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 on exertion
- Dependent upon adaptive device(s)
- Medical Restrictions
- Other, please specify _____

Place a check mark in appropriate box.

FUNCTIONAL STATUS GOALS

- Pt/CG performs ADL at max, level of independence
- Pt/CG performs procedure related to care
- Pt/CG manage equipment related to care
- Patient to achieve maximum level of:
 - gait normal reciprocal pattern
 - Gait on level with _____
 - Gait on non-levels with _____
 - Gait on Stairs
 - Gait on curbs/ramp
 - Transfers
 - Toilet
 - Bed
 - Chair
 - Tub
 - Bed Mobility
 - Decrease risk of falls

KNOWLEDGE GOALS

- Pt/CG verbalizes understanding of:
 - Home/exercise program/ activity management
 - S/S of complications
 - Other: _____
 - Mobility Techniques
 - Safety
 - Adaptive Equipment
 - Assistive device
 - Joint Protection precaution
 - Safe Swallowing
 - Auditory comprehension techniques
- Pt/ CG identify necessary lifestyle changes which may improve health status (mandatoty for chronic illness)
- Pt/ CG identify home and environment safety measures

Patient to achieve maximum skills in:

- Feeding
- Homemaking
- Bathing with Equipment
- Auditory comprehension
- Safe swallowing
- Silent reading
- Writing
- Other: _____
- Pain Management
- Breathing Technique
- Vitals Management
- Caregiver competence
- Pressure Relief
- Energy Conservation
- Balance Sit or Stand
- Strength
 - UE
 - LE
 - Trunk
- Postural Alignment
- Coordination of UE Gross or fine
- Coordination of LE Gross
- Endurance for functional activities/ADL/IAL/Mobility
- W/C mobility/ safety

Pt/ CG demonstrates compliance with:

- Home/exercise program/ activity management
- Appropriate response to complications
- Other: _____
- Mobility Techniques
- Safety
- Adaptive Equipment
- Assistive device
- Joint Protection precaution
- Safe Swallowing
- Auditory comprehension techniques
- Fall risk prevention
- Home Modifications

Therapist's Name/ Signature/ Title

Date