Evaluation Example

Evaluation Date: 01/06/2016
Treatment Time: 09:00 to 10:00
Patient Name: Henry Smith
DOB: 3/22/1957

Physician: Dr. James Anderson
Medical Diagnosis: M17.12 Left knee OA s/p TKA 12/28/15
PT treatment diagnosis: R26.9 Unspecified abnormalities of gait and mobility

Subjective: The patient is a 59 year old male who presents with complaints of left knee pain s/p TKA performed on 12/28/15. The patient reports having knee pain for years before he consulted with an ortho surgeon in August of 2015. An Xray revealed severe arthritis and the patient elected to undergo total knee replacement in December of 2015. The patient reports the surgery was performed with no issue. He was released home after a one night stay at the hospital. The patient lives with family who is able to assist with driving him to appointments until cleared by physician to drive. The patient's goals are to return to working as a supervisor at the local car manufacturer, and to 'walk without a walker or cane as soon as possible."

Past Medical History: High blood pressure

Previous PT: Yes, home health 4 days after surgery

Meds: Norco, tramadol, aspirin, lisinopril

Social History: Patient is married and lives in 2 story home with 4 steps to enter and 13 stairs to basement and upstairs. Master bedroom/bathroom on the main floor.

CC: Increased pain and stiffness in left knee prevents him from sleeping well at night and limits his ability to walk or stand for more than 10 minutes.

Precautions: WBAT with FWW progressing to cane as tolerated

Barriers to Learning: none

Home Barriers: 4 steps to enter home

Prior Functional Level: Patient was independent in all areas. Patient is active in his work as a floor manager at local car manufacturer and stand 8 to 10 hours a day, navigating stairs throughout the facility.

Objective:

Cognition: AOx3

Vital Signs: BP 122/88, HR 76, RR: 16

Posture: Patient stands with forward flexed trunk position using walker and demonstrates favoring of left knee in keeping it flexed.

Pain Scale / location / behavior: Patient presents with pain located along the left joint line lateral to the left patella. Patient denies tenderness behind the knee and along the incision. Pain increases with knee flexion, described as 'tightness' due to increased swelling. Patient rates pain at 4/10 at present, 3/10 at best and 6/10 at worst. Patient reports decreased sensation along incision line; sensation intact otherwise.

Integumentary: Surgical incision noted along midline of left knee. Steri strips present along 20 cm incision. Skin appears dark pink, dry and well healing. No open areas noted. Mild to moderate edema noted at knee with pitting noted as 1+ at tibia. No signs of infection noted.

Lower Extremity Functional Outcome Score: 55% disability score

ROM / Strength

* = pain	MMT R	MMT L	A/PROM (R)	A/PROM (L)
Knee Flexion	5/5	4/5	125/125	75 / 80 *
Knee Extension	5/5	3+/5	0 / 0	-5 / - 3 *
Hip Flexion	5/5	4/5	120	120
Hip Extension	5/5	4/5	10	10
Hip Abduction	5/5	4/5	WNL	WNL
Ankle Dorsifl.	5/5	5/5	WNL	WNL
Ankle Plantar.	5/5	4/5	WNL	WNL

Gait: Patient ambulates on level surfaces with FWW. He demonstrates gait deviations to include: increased lateral trunk lean to the left with stance phase, decreased push off bilaterally, poor knee flexion with swing, decreased hip extension with push off and

impaired ability to turn corners due to unsteadiness attributed to unnatural use of walker. Advised patient on safe use of walker to encourage proximity to device.

Balance: Rhomberg stance: positive, Single leg stance: unable on Left, 3 seconds on Right. Tandem stance: requires UE support with balance loss upon perturbation.

Reflexes: DTR intact at ankle; not tested at knee due to incision at knee.

Extensibility: Tightness notes in the following muscle groups: bilateral hamstring, quadriceps, gastroc/soleus.

Special Tests: PDVT Screen: negative

Treatment Provided: Total knee protocol to include instruction of HEP and performance of the following exercises: Ankle pumps x 20, Quad sets x 15, SLR x 10, Sidelying SLR x 10, Glute squeezes x 20, mini squats x 10, heel slides x 15. Cold pack x 10 minutes in supine following ther ex.

Assessment

Problem Summary: Increased pain at left knee, decreased ROM of left knee, decreased strength of L LE, balance deficits in standing, difficulty with weight bearing activities, altered posture, lack of home exercise program, impaired gait form and use of assistive device.

Assessment Statement: Patient presents with signs and symptoms consistent with diagnosis of L knee OA, s/p 1 week post operative L TKA. Rehab potential is excellent. Key impairments include: decreased ROM and strength of the left lower extremity, poor balance and compensatory gait patterning, increased swelling, and pain with functional activities such as squatting, walking, and stairs. Skilled PT is required to address these key impairments and to provide and progress with an appropriate home exercise program. This evaluation is of moderate complexity due to the changing nature of the patient's presentation as well as the comorbidities and medical factors included in this evaluation.

Goals:

Short Term Goals:
The patient will achieve 90˚ of knee flexion consistently in 2 weeks in order to progress with functional activities such as rising from a chair with equal weight bearing.

Within two weeks the patient will demonstrate improved quad strength and motor control as noted by ability to perform SLR without lag in order to progress into advanced ther ex.

The patient will report a 20% reduction in knee pain at night within 2 weeks in order to facilitate their ability to fall asleep.

Long Term Goals:
The patient will demonstrate increased knee flexion AROM to 120 within 6 weeks in order to improve the patient's ability to descend 2 flights of stairs at work.

The patient will demonstrate an increase in quadriceps strength by 1 MMT grade within 5 weeks in order to allow him the ability to ascend and descend stairs without the knee buckling.

The patient will demonstrate independent ambulation on level surfaces without straight cane within 4 weeks in order to allow patient to safely navigate the community without gait compensation.

The patient will report the ability to walk for 45 minutes without knee pain within 6 weeks in order to perform work tasks such as navigating the plant facility.

Plan: Patient will be seen by a PT and/or PTA two times per week for 6 weeks under the diagnosis of Left knee OA s/p L TKA and will be reassessed every 7-10 visits for progress.

Treatment to Include: AROM/AAROM/PROM, balance and proprioception training, strengthening exercises, HEP, mobilization, posture/body mechanic training, neuromuscular re-education, ice pack, to LLE.

Certification period: 1/6/16 - 2/24/16

The patient has been educated in the evaluation findings, prognosis, and plan of care, and is in agreement and willing to participate in therapy.

Thank you for this referral and please call xxx-xxx-xxxx with any questions or concerns.

Physical Therapist: _____ Date:_____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

Daily Note Example

Treatment Date: 01/08/2016
Treatment Time: 10:00 to 10:50
Patient Name: Henry Smith
DOB: 3/22/1957

Physician: Dr. James Anderson
Medical Diagnosis: M17.12 Left knee OA s/p TKA 12/28/15
PT treatment diagnosis: R26.9 Unspecified abnormalities of gait and mobility

Subjective: Patient stated "I am better able to sleep at night with less throbbing in my knee. Today my pain level is 3/10."

Objective: Patient using FWW to ambulate into clinic with equal step length noted.

20 minutes Therapeutic Exercise (97110): Supine exercises to include: active quad sets x15, SLR x 15, Hamstring curl x 10 with ankle dorsiflexion x3 each rep, SAQ with bolster x 15. PROM flexion to 95 degrees. Standing: mini squats x 10, hip abduction x 10 bilaterally, hamstring curls x 15 bilaterally, step up to 3" step x 10 alternating LE.

10 minutes Neuromuscular Re-education (97112): Weight shifting on balance pad 3x20 seconds, Rhomberg stance on pad 3x20 seconds with one UE support, semi tandem stance with perturbations from therapist 2x1 min, rocker board for proprioceptive training x 3 min.

10 minutes Manual Therapy (97140): Seated tibiofemoral distraction grade 2 mobilization for pain relief, supine patellar mobilizations in superior/inferior direction: grade 2 x 4 minutes, mobilization with movement of patella with SAQ x 3 minutes.

10 minutes 97010: Cold pack left knee patient in supine with knee supported by bolster for comfort following exercises and treatment. Instructed patient to continue the use of ice intermittently at home with elevation throughout the day to minimize swelling.

Assessment: The patient demonstrates lack of quad muscle recruitment during knee extension. Instructed patient in co-contraction of quads to improve motor recruitment in order to achieve greater knee extension. Poor balance on uneven surface noted during treatment. Continued use of FWW recommended.

Plan: Progress patient with strengthening exercise to increase quad activation and trial straight cane at parallel bars.

Therapist Signature: _____ Date: _____ Time: _____

CPT Code	Procedure	Unit / Time
97110	Therapeutic Exercise	1 / 20 minutes
97112	Neuromuscular Re-ed	1 / 10 minutes
97140	Manual Therapy	1 / 10 min
97010	Cold Pack	1 / 10 min

Ready to *STOP* spending 1-2 hours writing documentation after work?

- **Are you spending your lunch on documentation?**
- **Do your notes sound repetitive?**
- **Are you stressed about doing documentation at home?**
- **Do you feel embarrassed with your writing abilities?**

The number one complaint of therapists in almost every clinic is **time spent documenting**.

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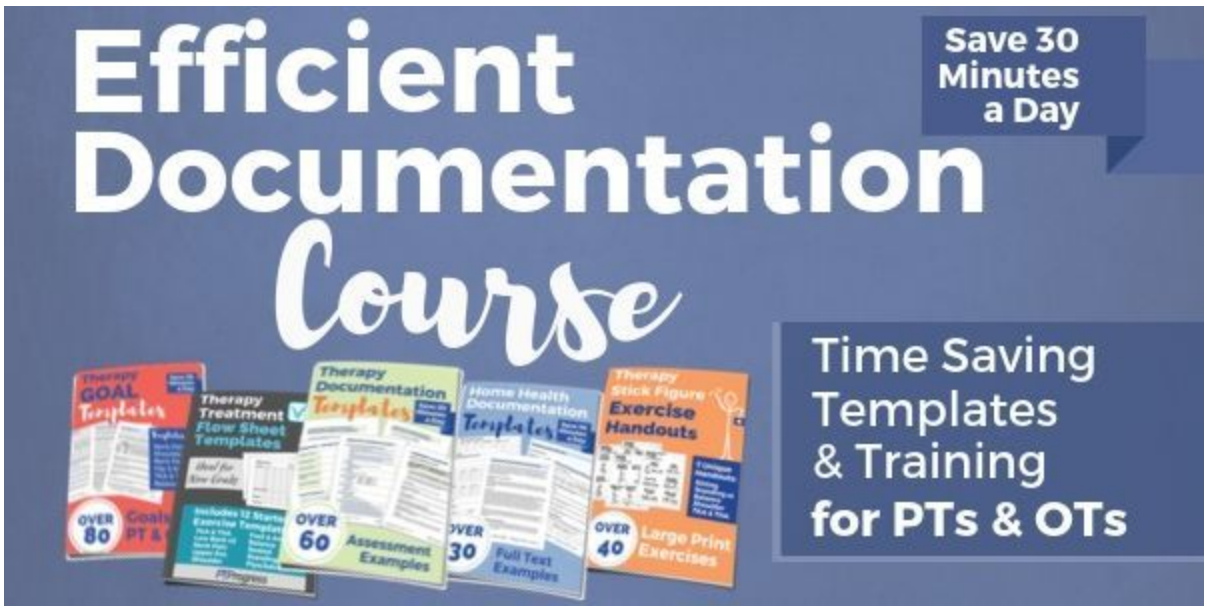

Progress Note Example

Treatment Date: 01/27/2016 Treatment Time: 10:00 to 11:00
Time Period: 01/06/16 to 1/27/16 Start of Care: 1/6/16
Patient Name: Henry Smith DOB: 3/22/1957

Physician: Dr. James Anderson
Medical Diagnosis: M17.12 Left knee OA s/p TKA 12/28/15
PT treatment diagnosis: R26.9 Unspecified abnormalities of gait and mobility

Subjective: Pain/Location 2/10: Patient states, "my knee pain has decreased significantly, allowing me to sleep through the night and to sit and stand from chairs much easier. I can walk for about 20 minutes with the cane before I need to sit to rest."
Attendance: Number of Treatments: 7 Cancellations: 0 No Shows: 0
Treatment Included: Ther ex, neuromuscular re-ed, manual therapy, cold pack, HEP

Objective Findings: SLR lag: 1 degree, rhomberg test: negative, sensation: intact, incision: closed, clean, and well healing. Patient uses straight cane for ambulation.

* = pain	MMT R	MMT L	A/PROM (R)	A/PROM (L)
Knee Flexion	5/5	4+/5	125/125	100 / 110
Knee Extension	5/5	4/5	0 / 0	-2 / - 2 *
Hip Flexion	5/5	4+/5	120	120
Hip Extension	5/5	4+/5	10	10
Hip Abduction	5/5	4+/5	WNL	WNL
Ankle Dorsifl.	5/5	5/5	WNL	WNL
Ankle Plantar.	5/5	4+/5	WNL	WNL

Assessment & Goal Status: The patient is progressing well towards goals established at evaluation, achieving 100% of short term goals. Long term goals to be addressed with further treatment. Patient lacks full strength to ascend full flight of stairs reciprocally and impaired balance on dynamic surfaces.

Plan: ☐ Discharge from PT x Continue PT 2 times per week for 3 weeks
To focus on quad strengthening, stair navigation, balance training, and gait training.
Therapist Signature: _____ Date: _____ Time: _____
Physician Signature: _____ Date: _____ Time: _____
Please sign and fax to: _____

documentation of therapeutic treatment / CPT codes should follow the example of the daily note. Therapy treatment flow sheet not included in this example.

PTProgress

Discharge Note Example

Treatment Date: 02/17/2016 Treatment Time: 10:00 to 11:00
Time Period: 01/27/16 to 02/17/16 Start of Care: 1/6/16
Patient Name: Henry Smith DOB: 3/22/1957

Physician: Dr. James Anderson
Medical Diagnosis: M17.12 Left knee OA s/p TKA 12/28/15
PT treatment diagnosis: R26.9 Unspecified abnormalities of gait and mobility

Subjective: Pain/Location 0/10: Patient states, "I no longer need to use the cane and have been able to navigate up and down my steps 8 times a day. My LE swells when I stand more than 3 hours at a time, but resting for 20 minutes allows me to stand throughout the day. I plan to return to work March 7th following my visit with the surgeon on 3/4/16."
Attendance: Number of Treatments: 13 Cancellations: 0 No Shows: 0
Treatment Included: Ther ex, neuromuscular re-ed, manual therapy, cold pack, HEP

Objective Findings: Rhomberg test: negative, sensation: intact, incision: closed, clean, and well healing. LEFS: 10% perceived impairment. No assistive device used.

* = pain	MMT R	MMT L	A/PROM (R)	A/PROM (L)
Knee Flexion	5/5	5/5	125/125	120 / 120
Knee Extension	5/5	5/5	0 / 0	0 / 0
Hip Flexion	5/5	5/5	120	120
Hip Extension	5/5	5/5	10	10
Hip Abduction	5/5	5/5	WNL	WNL
Ankle Dorsifl.	5/5	5/5	WNL	WNL
Ankle Plantar.	5/5	5/5	WNL	WNL

Assessment & Goal Status: The patient has achieved 100% of short term and long term goals. He demonstrates overall improved strength and stability with functional activities and with gait form. Patient is independent with advanced HEP and is agreeable to discharge with all goals met.

Plan: x Discharge from PT with all goals met.
Therapist Signature: _____ Date: _____ Time: _____
Physician Signature: _____ Date: _____ Time: _____
documentation of therapeutic treatment / CPT codes should follow the example of the daily note. Therapy treatment flow sheet not included in this example.