

Physical Therapy Evaluation

Patient Last Name, First Name, M.I.	Patient #	HIC #
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Reason for Referral:

Contraindications/Precautions: " Yes " No Specify:

Limitation in Joint ROM noted in (MDS G-4: A) " Not tested " No deficits Joint/Measurement: Joint/Measurement: Joint/Measurement: Joint/Measurement:	Functional Problems related to ROM Deficits:
Motor Response (MDS G-4: B) " Not tested " No deficits Muscle Group/Strength grade/Tone: Muscle Group/Strength grade/Tone: Muscle Group/Strength grade/Tone: Muscle Group/Strength grade/Tone:	Functional Problems related to Strength Deficits:

Level of Assistance: Independent=I; Modified Independent=Mod I; Stand By Assist=SBA; Supervision=S; Contact Guard Assist=CGA; Minimum=Min; Moderate=Mod; Maximum=Max; Dependent=D
 Weight Bearing: Full=FWB; Partial=PWB; Toe Touch=TTWB; None=NWB; Weight Bearing as Tolerated=WBAT
 Assistive Devices: Front Wheeled Walker=FWW; Standard Walker=SW; HemiWalker=HW; Large Based Quad Cane=LBQC; Small Based Quad Cane=SBQC; Straight Cane=SC

Functional Mobility (MDS G1 a,b,l)	Level of Assist.	Comments	Pain (rate on scale of 1-10): (MDS J-2,3) " None
Bed Mobility	Rolls Right		
	Rolls Left		
	Supine to Sit		
	Sit to Supine		
	Scouting		
Transfers			Sensory:
Gait	Weight Bearing		Skin Integrity:
	Distance		
	Time Taken		
	Assistive Device		
	Level of Assist.		
	Stair #/Assist.		
W/C	Mobility		Activity Tolerance:
	Management		
Balance (MDS G-3)	Sit Static		Posture:
	Sit Dynamic		
	Stand Static		
	Stand Dynamic		

Skilled Analysis of Bed Mobility/Transfers/Balance (risk factors, safety concerns):

Comments:

Therapist Signature/Credentials/Date: _____

Physician's Name: _____ **Patient's Room #** _____