

Therapy Progress Note for Remote Visit Using Telecommunication Technology

Visit: Remote Completed by PT OT SLP PTA OTA Start Time: _____ End Time: _____

Patient Name: _____ Caregiver Name: _____

Functional Impairments: _____

9 Dyspnea on exertion

Pain Assessment: Location: _____ Duration: _____

Intensity: 0 1 2 3 4 5 6 7 8 9 10

Current pain control:

Prior to treatment: BP _____ Pulse _____ Respiration _____ Pulse Ox _____ %

After treatment: BP _____ Pulse _____ Respiration _____ Pulse Ox _____ %

Objective/Subjective Findings: _____

Treatment : _____

Patient/Caregiver response to skilled services provided this visit: _____

Progress toward Goals on the Plan of Care (Measurement of physical outcomes of treatment and/or description of the changed behaviors due to education): _____

Continued Skilled Need (provide detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences, the complexity of the service to be performed, and any other pertinent characteristics of the beneficiary or home): _____

Care planned for next visit (based on the rationale of prior results): _____

Technology (application/device) used: _____

Who is onsite with the patient during the visit _____ (names)

Assistance provided Yes No Describe _____

Therapist's Signature/Date _____

Supervisor Name, if PTA or OTA _____