Physical Therapy Progress Note for Remote Visit Using Telecommunication Technology

Start Time: _____ End Time: _____

Patient Name	Patient Signature

Professional Services Provided - Check All That Apply

□ Evaluation □ Therapeutic Exercises □ Strengthening □ Balance Activities □ Facilitation □ ROM (P/AA/Active)
□ Coordination □ Mobilization □ Stretching □ Transfer Training □ Rolling/Bed Mobility □ Supine to Sitting
□ Bed to W/C □ W/C to C hair □ W/C to BSC □ Toilet □ Establish-Upgrade Home Prog □ Gait Training
□ Pattern _____ □ Assistive Device Used _____ □ Weight Bearing ____Full ____Partial ____None
□ Ultra Sound □ Electro therapy □ Prosthetic Therapy □ Fabrication Temp Devices □ Muscle Re-Education
□ Wound care □ Other

Primary Diagnosis:

Functional Impairments:

Dyspnea on exertion

Pain Assessment: □ No pain Location: Duration: Intensity: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
Current pain control:

Objective / Subjective Findings: update comprehensive health assessment

Treatment Provided/Plan of Care:

Technology (application/device) used:_____
Who is onsite with the patient during the visit _____**(names)**
Assistance provided ❑Yes ❑ No Describe_____

Coordination of Care: NA Dr. RN PT PTA OT OTHER Regarding:

□ 5 day discharge notice given to patient/physician

Therapist's Signature/Date Supervisor Name