DISCHARGE INFORMATION: □ Planned Discharge □ Unplanned Discharge (physician order required)
□ Discharge patient from PT due to: □ Goals Met □ Patient able to go to out patient therapy □ PLOF restored □ Maximum Potential achieved □ Patient/Caregiver I with HEP □ Caregiver Training Complete □ Patient Request

OR
□ Discharge patient from Home Health (All Services) due to □ Patient no longer homebound □ Goals Met □ No skilled needs □ Patient requests discharge □ Other _______________. □ SN to complete D/C Oasis.

Patient will be discharged to care of: _______________ with □ HEP □ Equipment _______________

Discharge Condition: □ Excellent □ Good □ Fair □ Guarded □ Poor □ Terminal

BP: ___________ Pulse: _______ RR: ______  Temp: ________ O2 Sat: (at rest) ____________
(w/ exertion) _______________

Pain: □ None □ Present
Location: ________________________________
Type: ___________________________

Onset/Frequency: _____________________________________

Present Intensity: ________ 0-10 scale

Precipitating Factors (Rate @ worst): __________________________

Alleviating Measures (@ best):______________________

Acceptable level of pain for the patient 0-10 scale: _________________________________________________________________

Home structure/household barriers that may impact the POT: ____________________________________________________________________________

Patient continues to be Homebound? □ Yes □ No
Taxing effort to leave home due to □ SOB with min exertion □ Pain with Ambulation □ Unsteady gait, requires assist to ambulate □ contraindicated to leave home □ other: _______________

SUBJECTIVE:

FUNCTIONAL ASSESSMENT:

<table>
<thead>
<tr>
<th>BED MOBILITY:</th>
<th><strong>QUALITY/DEFICIT</strong></th>
<th>AMBULATION:</th>
<th><strong>QUALITY/DEFICIT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolling R / L</td>
<td>Assistive Device</td>
<td>Indoor level</td>
<td>Distance and Assistive Device</td>
</tr>
<tr>
<td>Scooting R / L</td>
<td></td>
<td>Indoor unlevel</td>
<td></td>
</tr>
<tr>
<td>Bridging</td>
<td></td>
<td>Outdoor level</td>
<td></td>
</tr>
<tr>
<td>Supine to sit</td>
<td></td>
<td>Outdoor unlevel</td>
<td></td>
</tr>
<tr>
<td>Sit to supine</td>
<td></td>
<td>Up step/stairs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRANSFERS:</th>
<th></th>
</tr>
</thead>
</table>
| Sit to stand| SOB with Amb: □ Yes □ No Increased Pain with Amb: □ Yes □ No
| Stand to sit| WB Restriction: □ No □ Yes Location: ___________ □ NWB □ PWB % ________
| On/off toilet | □WBAT □FWB |
| In/out shower/tub | BALANCE: □Balance is WFL □ Moderate Risk □ High Risk □ Fall Risk is: □Low Risk
| In/out car | History of falls? □ Yes □ No
| Pivot | Frequency of Falls: ___________ Most Recent Fall: ___________

<table>
<thead>
<tr>
<th>POSTURE:</th>
<th></th>
</tr>
</thead>
</table>

STRENGTH/ROM ASSESSMENT:

<table>
<thead>
<tr>
<th>RUE</th>
<th>LUE</th>
<th>RLE</th>
<th>LLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROM WNL</td>
<td>ROM WFL</td>
<td>ROM Restriction</td>
<td>Strength WNL</td>
</tr>
</tbody>
</table>

TREATMENT RENDERED TODAY: (Mark all that apply indicate SPECIFIC treatments along with the frequency, duration, repetitions, and modalities parameters)

□ Re-Evaluation of current physical and functional status, therapy needs and rehab potential
□ Silver Steps Program (Please see attached Silver Steps documentation)
□ Transfer Training:
□ Gait Training:
□ Therapeutic Exercise:
□ Balance Training:

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PT DISCHARGE SUMMARY/VISITNOTE

UnitBranch: ____________  SunCrest Home Health  Patient Name: _______________________

Patient ID#: ___________________  Adm / Eps #: _______________________

□ Modalities: _________________________
□ Instruction in pain management: _________________________
□ Instruction in safety/precautions: _________________________
□ Instruction in HEP: _________________________
□ Patient / Caregiver Training: _________________________
□ Other: ______________________________________________________________________

Other: ______________________________________________________________________

□ Clinical Summary: ___________________________________________________________
□ Functional Status at PT SOC: □ Dependent □ Needed Assistance □ Needed Supervision □ Mod I □ Independent
□ Functional Status at PT D/C: □ Dependent □ Needs Assistance □ Needs Supervision □ Mod I □ Independent
□ D/C Recommendations: □ Follow Up with MD □ Follow Up with Outpatient Therapy □ Continue Independent HEP
□ Caregiver supervision recommended □ Other: _____________________________________

□ PT Clinical Summary SOC to D/C(Summary should reflect why stated goals below were met, partially met, and/or not met):

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

PROGRESS TOWARDS GOALS:

□ 1. PT final evaluation of physical and functional abilities, therapy needs and rehab potential completed.
□ 2. Patient and /or caregiver demonstrate knowledge of safety instructions and perform HEP independently.
□ Goal: □ Met □ Partially Met □ Not Met
□ 3. Patient’s bed mobility □ rolling □ scooting □ supine to sit improved from _______ (PT SOC) to _______ (PT D/C)
□ Goal: □ Met □ Partially Met □ Not Met
□ 4. Patient’s transfers □ sit to stand □ bed to commode/Chair □ shower/tub □ other __________ improved from _______ (PT SOC) to _______ (PT D/C)
□ Goal: □ Met □ Partially Met □ Not Met
□ 5. Patient’s ambulation improved from □ level surfaces □ uneven surfaces □ up/down step/stairs with ______ device with assistance for _______ feet to □ level surfaces □ uneven surfaces □ up/down step/stairs with ______ device independently or with ______ assistance for _______ feet.  □ Goal: □ Met □ Partially Met □ Not Met
□ 6. Patient’s ROM of ___________ increased from _______ to _______ enhancing patient’s functional mobility.
□ Goal: □ Met □ Partially Met □ Not Met
□ 7. Patient’s strength of ___________ increased from _______ to _______ enhancing patient’s functional mobility.
□ Goal: □ Met □ Partially Met □ Not Met
□ 8. Patient’s sitting / standing balance improved from _______ to independent or _______ assistance, reducing fall risk and enhancing patient’s functional mobility. Balance scores improved to: □ TUG □ Tinetti □ balance ______ gait or □ Other ______.  Goal: □ Met □ Partially Met □ Not Met
□ 9. Patient’s pain level in ___________ decreased from ___/10 to ___/10 enhancing patient’s functional mobility.
□ Goal: □ Met □ Partially Met □ Not Met
□ 10. Patient / caregiver educated on and demonstrate knowledge of ______________________
□ Goal: □ Met □ Partially Met □ Not Met
□ Other: _________________________
□ Other: _________________________
□ Other: _________________________
□ Other: _________________________
□ Other: _________________________

I certify that I have used Standard Precautions including proper handwashing technique, and I know where I can get personal protective equipment from the company for my use. I certify that the preceding information is correct to the best of my knowledge.

PT Signature: _________________________  Printed Last Name: _________________________

Patient Signature: _________________________

Date: _________________________

Physician Communication: □ Yes □ No Comments: _________________________

Case Manager Communication: □ Yes □ No Comments: _________________________

Other: _________________________

Physician Name: _________________________  Date Sent: _________________________

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