

**NORTHCOAST HEALTH CARE MANAGEMENT SERVICES
PHYSICAL / OCCUPATIONAL THERAPY UPDATE FORM**

Provider: _____ Payor: _____

PATIENT: _____ Dates of Visits Since Last Auth: _____

Visit Classification: Assessment Ongoing Discharge Discipline: PT OT

FUNCTIONAL LEVEL		
Initial Status Date: _____	GOALS	Updated Status Date _____
RANGE OF MOTION RUE: _____ RLE: _____ LUE: _____ LLE: _____	RANGE OF MOTION RUE: _____ RLE: _____ LUE: _____ LLE: _____	RANGE OF MOTION RUE: _____ RLE: _____ LUE: _____ LLE: _____
STRENGTH RUE: _____ RLE: _____ LUE: _____ LLE: _____	STRENGTH RUE: _____ RLE: _____ LUE: _____ LLE: _____	STRENGTH RUE: _____ RLE: _____ LUE: _____ LLE: _____
AMBULATION WB Status: _____ # of feet: _____ Assistive Device: _____ Amount of Assist: _____	AMBULATION WB Status: _____ # of feet: _____ Assistive Device: _____ Amount of Assist: _____	AMBULATION WB Status: _____ # of feet: _____ Assistive Device: _____ Amount of Assist: _____
ADL's - Assist Bathing: _____ Dressing: _____ Grooming: _____ Feeding: _____ Home Making: _____	ADL's - Assist Bathing: _____ Dressing: _____ Grooming: _____ Feeding: _____ Home Making: _____	ADL's - Assist Bathing: _____ Dressing: _____ Grooming: _____ Feeding: _____ Home Making: _____
ENDURANCE: _____	ENDURANCE: _____	ENDURANCE: _____
BALANCE Sitting: _____ Standing: _____ Dynamic: _____	BALANCE Sitting: _____ Standing: _____ Dynamic: _____	BALANCE Sitting: _____ Standing: _____ Dynamic: _____
TRANSFERS Sit/Stand: _____ Bed: _____ W/C: _____ Toilet: _____ Floor: _____ Auto: _____	TRANSFERS Sit/Stand: _____ Bed: _____ W/C: _____ Toilet: _____ Floor: _____ Auto: _____	TRANSFERS Sit/Stand: _____ Bed: _____ W/C: _____ Toilet: _____ Floor: _____ Auto: _____
STAIRS # stairs to enter/exit home: _____ Assistance needed: _____	STAIRS # stairs to enter/exit home: _____ Assistance needed: _____	STAIRS # stairs to enter/exit home: _____ Assistance needed: _____
Other: _____	Other: _____	Other: _____

Current Progress / Medical Update: _____

**HOMEBOUND STATUS: _____

PROJECTED PLAN OF CARE # of Visits _____ wk _____ No further needs

Reason for visits: _____

STATUS AT DISCHARGE

- Goals Met _____ Goals not met due to: _____
 Patient aware of discharge MD notified of discharge

Signature: _____ Date: _____