

PHYSICAL THERAPY DAILY NOTE



| PATIENT INFORMATION | | |
|--|---|--|
| Last Name | First Name MI | HICN |
| VISIT INFORMATION | | |
| Date of Service | Visits From SOC | Date Of Treatment Plan/Recert. |
| HCPCS CODE | DESCRIPTOR OF SERVICE | TO ADDRESS |
| <input type="checkbox"/> 97110 Therapeutic Exercise Time _____ Units _____ | Performed with patient either active or actively assisting in the following: <input type="checkbox"/> Progressive resisted exercises <input type="checkbox"/> Active ROM Exercise LE <input type="checkbox"/> Trunk Stabilization <input type="checkbox"/> Contract relax technique <input type="checkbox"/> Education <input type="checkbox"/> Eccentric control training <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Gait/Posture <input type="checkbox"/> Balance <input type="checkbox"/> Transfers <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Functional Mobility |
| <input type="checkbox"/> 97112 Neuromuscular Re-Education Time _____ Units _____ | To improve balance, coordination, kinesthetic sense, posture and proprioception. To include: <input type="checkbox"/> PNF Techniques <input type="checkbox"/> Facilitation of Balance and coordination <input type="checkbox"/> NDT Techniques <input type="checkbox"/> Re-education of movement <input type="checkbox"/> Neuromuscular Re-Education <input type="checkbox"/> Joint Protection Techniques <input type="checkbox"/> Sensory Re-Education <input type="checkbox"/> Education <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Gait/Posture <input type="checkbox"/> Balance <input type="checkbox"/> Transfers <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Functional Mobility |
| <input type="checkbox"/> 97116 Gait Training Time _____ Units _____ | Skilled training to address walking abilities impaired by injury or trauma to include <input type="checkbox"/> Rhythm <input type="checkbox"/> Assistive Device Training <input type="checkbox"/> Cadence <input type="checkbox"/> Base of Support Retraining <input type="checkbox"/> Step/Stride <input type="checkbox"/> Weight bearing retraining <input type="checkbox"/> Speed <input type="checkbox"/> Stair Climbing <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Gait <input type="checkbox"/> Functional Mobility |
| <input type="checkbox"/> 97140 Manual Therapy Time _____ Units _____ | Includes the following modalities: <input type="checkbox"/> Manual Traction Areas of Treatment: <input type="checkbox"/> Joint Mobilization <input type="checkbox"/> Soft Tissue Mobilization <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Gait/Posture <input type="checkbox"/> Balance <input type="checkbox"/> Transfers <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Functional Mobility |
| <input type="checkbox"/> 97542 W/C Mngt Propulsion Time _____ Units _____ | To train the patient in functional activities that promote safety, mobility and transfers. <input type="checkbox"/> Propulsion Training <input type="checkbox"/> Education <input type="checkbox"/> Obstacle Training <input type="checkbox"/> Other: <input type="checkbox"/> Ramps/Inclines <input type="checkbox"/> Safety Techniques | <input type="checkbox"/> Gait/Posture <input type="checkbox"/> Balance <input type="checkbox"/> Transfers <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Functional Mobility |
| <input type="checkbox"/> 97520 Prosthetic Training – Education for application and functional use of a prosthetic | | |
| Time _____ Units _____ | | |
| <input type="checkbox"/> Other Procedure: Describe Time _____ Units _____ | | |

Document objective and specific progress to date; attainment of goals; describe if necessary the need for treatment not included on original plan of care

Patient not currently receiving Home Health Services
 Plan Continue Plan of Tx Prepare for Discharge (complete Beneficiary Notice) Projected D/C Date: _____

Start Time _____ AM PM Stop Time _____ AM PM Total Time/Units _____

| | |
|--|---|
| Patient Signature: I certify that I was seen today by the Physical Therapist/PTA and agree that the time spent for my care is correct. I understand and agree to the Goals and Plan of Care developed. X | Therapist's Name & Credentials (Please Print) Therapist's Signature X |
|--|---|