Company Name

Therapy and/or Medical Social Services SKILLED VISIT NOTE

☐ CHARGEABLE
☐ NON-CHARGEABLE

Patient Last Name	First Name	Pt. ID #	Date

TIME		VISIT CODE	AIDE SUPERVISORY VISIT			PAIN
IN	OUT	1. Chg. Admissions 2. Chg. Visits 3. Supervisory Visit 4. Other N/C Visit	Patient satisfied with care	☐ Yes	☐ No	☐ No Pain at present time Location: ___ Intensity: 1 2 3 4 5 Patient's pain goal: ___ Teaching: ___ Current pain management: ___
			HHA following care plan	☐ Yes	☐ No	
			Care plan updated	☐ Yes	☐ No	
			Comments ___			

SKILLED SERVICES PROVIDED:

Physical Therapy

- B01 ☐ Evaluation
- B02 ☐ Therapeutic Exercise
- B03 ☐ Transfer Training
- B04 ☐ Home Program
- B05 ☐ Gait Training
- B06 ☐ Chest Physiotherapy
- B07 ☐ Ultrasound
- B08 ☐ Eltro Therapy
- B09 ☐ Prosthetic Training
- B10 ☐ Fabricate Temp. Devices
- B11 ☐ Muscle Re-education
- B12 ☐ Management & Evaluation of a Patient Care Plan

Speech Therapy

- C01 ☐ Evaluation
- C02 ☐ Voice Disorders Treatment
- C03 ☐ Speech Articulation
- C04 ☐ Dysphagia Treatment
- C05 ☐ Language Disorder Treatment
- C06 ☐ Oral Rehabilitation
- C07 ☐ Non-Oral Communication

Medical Social Service

- E01 ☐ Assessment of Social & Emotional Factors
- E02 ☐ Counseling for Long Range
- E03 ☐ Community Resource Planning
- E04 ☐ Short Term Therapy

Occupational Therapy

- D01 ☐ Evaluation
- D02 ☐ ADL Skills / Training
- D03 ☐ Muscle Re-Education
- D04 ☐ Perceptual Motor
- D05 ☐ Fine Motor Coordination
- D06 ☐ Neuro-Development Treatment
- D07 ☐ Sensory Treatment
- D08 ☐ Orthotics / Splinting
- D09 ☐ Adaptive Equipment

Other ___

Blood Pressure ___ Pulse ___ Respiration ___

Observation / Assessment Date ___
(use objective measurement) ___

Skilled Care / Instructions Provided ___

Response to Skill Teaching ___

M.D. Contact: Status Report, Unstable Condition - *(Specify)* ___

Plan ___

Patient Name ___ **Signature** ___ **Date** ___

Clinician's Name ___ **Signature** ___ **Date** ___

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