July 26, 2019

Fast Facts Friday

Components of a Comprehensive Evaluation and eDoc

Activity	Key Information	POC Document	Regulation/Policy/ Documentation Tip
Chart Review Patient/Caregiver Discussion	Prior level of function	Functional deficits-Prior level of Function	Click the green + sign before adding any Functional deficits Prior level of function can be based on patient/caregiver report.
	Background Information	*Blue Box areas:* Medications, Medical History, Environmental Factors/ Social Support, Prior Residence and Living arrangements, previous Therapy, precautions, informed consent.	***Remember: Use Tool Tips at the top of each screen.***
	Patient/ Caregiver Goal	LTG(S) Additional information in functional deficits	Select overarching Longs Term Goals based on the patient/caregiver goals. ***Use the additional information box to further clarify the LTG.***
	Reason for Referral	Reason for Referral	Reason for referral as it relates to function/safety caused by the prior or treating diagnosis. What was the change in function that necessitates therapy?

Activity	Key Information	POC Document	Regulation/Policy/ Documentation Tip
Evaluate the patient	Current Level of Function	Functional Deficits- Current Level of Function	Always click green plus before adding any information in functional deficits - this will speed up entry and display all areas under functional deficits.
	Baseline for functional areas and Standardized tests	Functional Deficits & Standardized test and Underlying impairments & Standardized tests	
	Areas of higher function that lead us to believe that the patient can make improvements	Functional Deficits prior and Current level of function	Remember to include the interpretation of standardized tests either in the additional information box or the Standardized test Blue box area.

Activity	Key Information	POC Document	Regulation/Policy/ Documentation Tip
Establish Treatment Plan	What underlying impairment areas need to be addressed to help the patient achieve their goals… for the next 2 weeks.	Treatment diagnosis Short Term Goals	Remember: Treatment diagnosis should be supported by information in the deficits and impairments. Underlying impairment will paint the picture of what and why skilled services are needed. You can add information to short term goals to customize the goal for the patient. Many Short term goals can be linked to a long term goal. Short terms goals can be upgraded, met and added throughout the course of treatment.
	Plans for Discharge Blue box area Treatment plan and approach	Discharge Plan, precautions, contraindications -blue box areas CPT codes, Anticipated treatment minutes, Diagnostic group and sub group, primary and secondary programs.	

Activity	Key Information	POC Document	Regulation/Policy/ Documentation Tip
Outcomes	GG items PT and OT NOMs ST	**Enter Prior and current level** only on GG items in functional deficits. Enter ST NOMS on worksheet/desktop	Only prior and current level required Goal can be left blank. NOMS - no change in process

Fast Facts Friday

NPORT

Click 'Tap Here To Add Deficit' **before** adding any deficits – this will allow you to see all functional deficits available and the screen will respond more quickly to entry.

Tap Here To Add Deficit

Tool Tips can be found at the top of each library for the Blue Box areas and will describe what type of information should be included in the documentation.

8000 - Smart Testing

Cancel | Reason For Referral | Save

Reason for the referral as it relates to function/safety caused by primary or treating diagnosis. If chronic condition, describe change in function necessitating recurring therapy. (The initial (ENTER) phrase can be removed but all others must be completed.)

(ENTER Amputee Chronic) This (ENTER age) year old (ENTER gender) was admitted with a (ENTER right or left) (ENTER type of amputation) for (ENTER time). The patient shows impaired function in (ENTER functional activities) and difficulty in management of (ENTER stump, prosthesis). Skilled therapy is

Remember to include the interpretation of standardized tests either in the additional information box or the Standardized test Blue box area.

Standardized Tests: BCAT 39/50 indicating mild cognitive impairment, relative strengths in visual recall, abstraction, visuospatial and story recall.

Standardized Tests: Berg Balance Measure = 34 indicating moderate risk for falls

STG can be 'linked' to LTGs by clicking on the LTG box next to the red X. Remember multiple STGs can be linked to one LTG.

ST-Goals - COG-Attention

Current Level

Patient attends to tasks for accuracy with verbal cueing for Ability to recall training s precautions.

Long Term Goal: Cognition / Recall / Safety-Judgement

Target Level

Patient will be able to attend to tasks for 90 seconds with 90% accuracy with no cues for ability to recall training sequences and new hip precautions sequences.

LTG should only be entered for the functional deficits that will be addressed and represent the overarching goals of the patient/caregiver.

Functional Deficit

	Prior Level	Current Level	Long Term Goal
Speech			
Intelligibility	independent (no pro...	independent (no pro...	
Voice			
Volume	independent (produ...	independent (produ...	
Language			
Expressive			
Auditory Comprehen...			
Auditory Discriminat...			
Follow Commands			
Reading Comprehen...	independent (81-10...	independent (81-10...	
Graphic Expression			
Cognition			
Cognition	independent (no pro...	moderate (51-70% a...	minimal (81-90% abil...
Orientation	person, facility, nursi...	person, place, and ti...	
Recall	independent (no pro...	moderate (51-70% a...	minimal (81-90% abil...
Safety-Judgement	independent (no pro...	moderate (51-70% a...	minimal (81-90% abil...
Follow Commands	independent (no pro...	mild (71-80% ability;...	

Please see separate sample Plan of Care (POC) documents attached to FFF.

Physical Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
Patient A				
PROVIDER NAME		**PROVIDER NO.**		**MRN/ID**
PHYSICIAN		**PAYOR** Medicare Part A		
MEDICAL DIAGNOSIS				
I63.81 (12/10/2018) Other cerebral infarction due to occlusion or stenosis of small artery				
TREATMENT DIAGNOSIS				
R26.81 Unsteadiness on feet (12/14/2018)				
START OF CARE 12/14/2018		**END OF CARE** 12/20/2018		

Prior Hospitalization: From Date: 12/10/2018 To Date: 12/13/2018 ☐ NA

Reason For Referral:

81-year-old male with complex medical history was taken to the ED from his place of work due to CVA symptoms. Patient presents with left hemiparesis, decreased sensation LUE/LLE, abnormal tone LUE/LLE, decreased proprioception left side, decreased coordination L, dysmetria L, decreased motor coordination and planning on the left, decreased insight into deficits, poor safety awareness, impulsiveness, unsteadiness on his feet resulting in high fall risk and a decline in all areas of functional mobility including bed mobility, all functional transfers and ambulation. It is not anticipated that patient will spontaneously recover. Without physical therapy services patient is at risk for falls, increased burden of care and decreased functional independence

Therapy Necessity:

Skilled physical therapy is required to improve strength, endurance, and balance in order to perform bed mobility, transfers and ambulation with Least restrictive assistive device including FWW, NBQC, SPC

Medical History Related to Diagnosis/Condition:

Recent R carotid thrombectomy, chronic anticoagulant, CAD s/p Coronary artery bypass graft, CHF with permanent pacemaker and automated implantable cardioverter-defibrillator, ventricular paced, A-fib on warfarin, restless leg syndrome, hyperlipidemia, gout, zoster, diabetes with diabetic neuropathy, L sh "injury"

Medications:

Anti-Hypertensives at risk for at risk for Chest pain, Cough, Depression, Dizziness, Fainting, GI disturbances, Headache, Lethargy, Lightheadedness, Nausea, Orthostatic, hypotension, Pedal edema, Possible exercise intolerance or A44Tachycardia Bronchodilators at risk for GI disturbances, Nervousness, Restlessness, Tachycardia, Trembling Diabetic Medications at risk for Abdominal discomfort, Anemia, Back pain, Blurred vision, Constipation, Decreased body temperature, Diarrhea, Dizziness, Fatigue, Headache, Hyperglycemia, Hypoglycemia, Increased blood pressure, Lactic acidosis, Light sensitivity, Liver problems, Muscle aches, Nausea, Rapid or trouble breathing, Respiratory tract infection, Sinus inflammation, Slow or irregular heartbeat, Swelling, Vomiting or Weakness Narcotic Pain Medications at risk for Addiction potential, GI irritation, Liver toxicity, Mental clouding, Respiratory depression or Withdrawal risk Non-Steroidal Anti-Inflammatories (NSAIDS) at risk for Bleeding of stomach and GI tract, Irritation or Ulceration Anti-Coagulants at risk for Excessive bruising, Hemorrhage (including rectal bleeding and coughing up blood), Heparin-induced hrombocytopenia (HIT syndrome)

Discharge Environmental Factors / Social Support:

Patient very active and independent with all ADLs and community mobility. Patient is primary caregiver for his wife. Patient was working full-time. Patient was driving. Patient has SPC but does not use

Prior Residence and Living Arrangement:

Patient lives with his wife in a single level home with two stairs to enter. Patient wife unable to assist due to auto immune disease

Previous Therapy:

Patient received Physical Therapy during the recent inpatient hospitalization.

Precautions:

AICD pacemaker, high Fall risk, L hemiparesis, impulsive, Aspiration precautions with mechanical soft diet and nectar thick liquids

Discharge Plans:

Discharge home and independent without caregiver.

Initial Assessment

Functional Deficits	Prior Level	Current Level	Long Term Goal
Balance, GG: Picking Up Object	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	Partial/moderate assistance- Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.	
Bed Mobility, GG: Roll left and right	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	Supervision or touching assistance- Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.	
Bed Mobility, GG: Lying to sitting on side of bed	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	04. Supervision or touching assistance-Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.

Physical Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
Patient A				

PROVIDER NAME	PROVIDER NO.	MRN/ID

PHYSICIAN	PAYOR Medicare Part A

MEDICAL DIAGNOSIS

I63.81 (12/10/2018) Other cerebral infarction due to occlusion or stenosis of small artery

TREATMENT DIAGNOSIS

R26.81 Unsteadiness on feet (12/14/2018)

START OF CARE 12/14/2018 **END OF CARE** 12/20/2018

Functional Deficits	Prior Level	Current Level	Long Term Goal
Bed Mobility, GG: Sit to lying	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	04. Supervision or touching assistance-Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.	
Standardized Tests, Functional Reach	15 inches	2 inches	
Standardized Tests, BERG Score	43/56	23/56 Medium fall risk	33/56 Medium fall risk
Gait, GG: Walk 10 feet	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	04. Supervision or touching assistance-Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.	
Gait, GG: Walk 50 feet with two turns	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	03. Partial/moderate assistance-Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.	
Gait, GG: Walk 150 feet	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	03. Partial/moderate assistance-Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.
Gait, Assistive Device	None	2-Wheeled Walker	
Gait, GG: Walking 10 feet on uneven surfaces	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	88. Not attempted due to medical condition or safety concerns.	
Gait, GG: 1 step (curb)	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	88. Not attempted due to medical condition or safety concerns.	
Gait, GG: 4 steps	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	88. Not attempted due to medical condition or safety concerns.	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.
Gait, GG: 12 steps	09. Not applicable	09. Not applicable	
Transfers, GG: Chair/bed-to-chair transfer	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	04. Supervision or touching assistance-Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.	
Transfers, GG: Sit to stand	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	04. Supervision or touching assistance-Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.
Transfers, GG: Car transfer	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	88. Not attempted due to medical condition or safety concerns.	
Transfers, GG: Toilet transfer	06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	88. Not attempted due to medical condition or safety concerns.	
Wheelchair Mobility/Management, GG: Does the resident use a wheelchair and/or scooter?	0. No	0. No	

Physical Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
Patient A				

PROVIDER NAME	PROVIDER NO.	MRN/ID

PHYSICIAN	PAYOR Medicare Part A

MEDICAL DIAGNOSIS

I63.81 (12/10/2018) Other cerebral infarction due to occlusion or stenosis of small artery

TREATMENT DIAGNOSIS

R26.81 Unsteadiness on feet (12/14/2018)

START OF CARE 12/14/2018	END OF CARE 12/20/2018

Functional Deficits	Prior Level	Current Level	Long Term Goal
Wheelchair Mobility/Management, GG: Wheel 50 feet with two turns	09. Not applicable	09. Not applicable	
Wheelchair Mobility/Management, GG: Indicate the type of wheelchair or scooter used.	09. Not applicable	09. Not applicable	
Wheelchair Mobility/Management, GG: Wheel 150 feet	09. Not applicable	09. Not applicable	
Wheelchair Mobility/Management, GG: Indicate the type of wheelchair or scooter used.	2. Motorized	09. Not applicable	

Functional Deficit Other

pt requires CGA for transfers and GT with FWW with CGA on straightaways but min assist during turning and maneuvering around obstacles due to left hemiparesis, decreased sensation LUE> LLE, abnormal tone LUE > LLE, decreased proprioception left side, decreased coordination L, dysmetria L, decreased motor coordination and planning on the left, decreased insight into deficits, poor safety awareness, impulsiveness.

Physical Therapy Plan Of Care

PATIENT LAST NAME / FIRST NAME / MI	DATE OF BIRTH	HIC NO.
Patient A		

PROVIDER NAME	PROVIDER NO.	MRN/ID

PHYSICIAN	PAYOR Medicare Part A

MEDICAL DIAGNOSIS
I63.81 (12/10/2018) Other cerebral infarction due to occlusion or stenosis of small artery

TREATMENT DIAGNOSIS
R26.81 Unsteadiness on feet (12/14/2018)

START OF CARE 12/14/2018 **END OF CARE** 12/20/2018

Underlying Impairments

Reflexes, Right LE
intact
Reflexes, Right UE
intact
Sensation, Left LE
impaired
Sensation, Left UE
impaired
Sensation, Right LE
intact
Sensation, Right UE
intact
Skin Integrity, Skin Discoloration or Bruising
See Narrative box
Skin Integrity, Swelling/Edema
See Narrative box below
Skin Integrity, Wounds
See Narrative box
Standardized Tests, Berg Balance
21-40 medium fall risk
Strength, Strength LLE
3-/5
Strength, Strength LUE
2-/5
Strength, Strength RLE
4-/5
Strength, Strength RUE
4-/5

Underlying Impairments Other
left hemiparesis, decreased sensation LUE>LLE, abnormal tone LUE> LLE, decreased proprioception left side, decreased coordination L, dysmetria L, decreased motor coordination and planning on the left, decreased insight into deficits, poor safety awareness, impulsiveness. Pain chronic L sh. Pt with skin discoloration, bruising, wounds and edema all 4 extremities

Standardized Tests
Berg Balance Measure = 23/56 = moderate fall risk but due to decreased safety awareness, impulsively, decreased insight into deficits = high

Timed Up and Go = 20 Sec with FWW with min assist for turning

Functional Reach = 2"

Pain Rating Scale = 3/10 chronic L sh

Goals	Goal Date
Bed Mobility - GG: Lying to sitting on side of bed (Section GG Scale scale): 06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	01/24/2019
STG: : Bed Mobility: The patient is able to safely supine < > sit with stand by assist (supervision) and with with 50% verbal, tactile and visual instruction/cues.	12/28/2018
Gait - GG: Walk 150 feet (Section GG Scale scale): 06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	01/24/2019
STG: : Ambulation-Specific: Pt. will ambulate > 150 feet safely with least restrictive assistive device 2-Wheeled Walker , NBQC, SPC and stand by assist (supervision) on even surfaces.	12/28/2018
Gait - GG: 4 steps (Section GG Scale scale): 06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	01/24/2019
STG: : Stair Climbing: Ascend/descend 4 stairswith rails with and CGA (Contact Guard Assist).	12/28/2018
Transfers - GG: Sit to stand (Section GG Scale scale): 06. Independent-Resident completes the activity by him/herself with no assistance from a helper.	01/24/2019
STG: : Transfer: General: The patient will safely perform all functional transfers increasing to stand by assist (supervision) with 50% verbal, tactile and visual instruction/cues.	12/28/2018

Physical Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
Patient A		R		
PROVIDER NAME		**PROVIDER NO.**		**MRN/ID**
PHYSICIAN		**PAYOR** Medicare Part A		
MEDICAL DIAGNOSIS I63.81 (12/10/2018) Other cerebral infarction due to occlusion or stenosis of small artery				
TREATMENT DIAGNOSIS R26.81 Unsteadiness on feet (12/14/2018)				
START OF CARE 12/14/2018		**END OF CARE** 12/20/2018		
Standardized Tests - BERG Score	(Berg Balance Scale scale): 33/56 Medium fall risk			01/24/2019
STG: : Berg - Risk for falls: Patient will demonstrate improved balance to 33/56 Medium fall risk as evidence by Berg Balance test results with improvement in safe transfers and amb				12/28/2018

Rehab Potential: Good **due to:** Able to follow 3 step directions. Independent in prior ambulation ability. Independent in prior level of function. Motivated to return Community activities, work, driving and taking care of wife. Oriented to X3. Patient motivated to return to personal home.

Informed Consent: Treatment plan, including benefits, risk and alternatives discussed with patient and/or family, who agree to treatment.

Patient Consent: Patient / Caregiver is aware and reports understanding of the diagnosis and prognosis.

Additional Information: Pt agreeable to POC

Contraindications: Contraindications noted for Modalities.Contraindications are secondary to AICD pacemaker.

Requires skilled services to focus on:

97110 - Therapeutic exercise 97112 - Neuromuscular reeducation 97116 - Gait training
97163 - PT eval high complex 97530 - Therapeutic activities 97537 - Community reintegration

Frequency/Duration: 5 times a week for 6 weeks

Electronically Signed by Therapist: **Date:** 12/14/2018

I agree, and it is my intent, to sign this record/document and affirmation of electronic signature for electronic submission and printed record/document. I understand that my signing and submitting this record/document in this fashion is the legal equivalent of having placed my handwritten signature on the submitted record/document and this affirmation.I understand and agree that by electronically signing and submitting this record/document in this fashion I am affirming to the truth of the information contained therein.

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Physician Name: ☑ Signature Required

Certification:

From 12/14/2018 To 01/24/2019

Speech Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.

PROVIDER NAME	PROVIDER NO.	MRN/ID
	0010010003	

PHYSICIAN Badalamenti, Linda (1073590865) | **PAYOR**

MEDICAL DIAGNOSIS
S82.122D Displaced fracture of lateral condyle of left tibia, subsequent encounter for closed fracture with routine healing (07/01/2019)

TREATMENT DIAGNOSIS
R41.841 Cognitive communication deficit (07/07/2019)

START OF CARE 07/07/2019 | **END OF CARE**

Prior Hospitalization: From Date: 07/01/2019 To Date: 07/07/2019 ☐ NA

Reason For Referral:

This 85 year old female presents to speech therapy with impairments in memory, problem-solving, attention, and executive function for 1 week/since recovery from surgery following left tibia fracture. The patient has shown a decline from WNL to moderate impairment in ability to complete IADLs and in functional safety awareness. Skilled speech therapy is necessary to improve attention/problem-solving/executive function in order to complete IADLs (medication management, finance management, etc) as well as safety awareness due to mobility constraints following surgery/fracture prior to returning home.

Therapy Necessity:

Patient was hospitalized 7/1/19 due to fall with L tibia fracture and subsequent surgical repair. Patient underwent anesthesia. Following surgery patient demonstrates decline in ability toperform IADLs. Skilled SLP is necessary for cognitive-linguistic treatment in order to improve Use of strategies for memory, attention, problemsolving,reasoning, and safety awareness to enhance independence with functional activities.

Medical History Related to Diagnosis/Condition:

Anxiety, CHF (Congestive Heart Failure), Diabetes -- Type I, History of falls, Osteoporosis,

Medications:

Diabetic medications with potential risk for abdominal discomfort, blurred vision, fatigue, light sensitivity, nausea, rapid or trouble breathing, andvomiting.

Discharge Environmental Factors / Social Support:

The patient's Spouse will be able to provide Verbal cues as needed, however physical assist may not be an option. Patient was providing physicalassist for balance support for spouse due to neuropathy. Spouse will need visual/verbal training in specific cues if necessary upon return home due to spouses noted mild memory deficits.

Prior Residence and Living Arrangement:

Patient lived in 2 story home with spouse. Required no cognitive support for basic ADLs or higher level IADLs. Patient managed own medications, aswell as spouses. Patient was driving and completed light house keeping. Deep cleaning and laundry assist 1x/week

Previous Therapy:

This patient has not had prior speech therapy for this same condition in the past year.

Precautions:

HOH - speak in deep voice. Reduce background noise, stand directly in front of patient, and speak in deep voice when communicating. Fall risk. 50% WB L LE.

Discharge Plans:

Home with husband to provide verbal cues for strategy use as indicated/trained.

Initial Assessment

Functional Deficits	Prior Level	Current Level	Long Term Goal
Speech, Intelligibility	independent (no problems)	independent (no problems)	
Speech, Volume	independent (production is normal in all situations)	independent (production is normal in all situations)	
Language, Expressive	independent (no problems)	mild (expresses needs 90% of time)	
Language, Reading Comprehension	independent (91-100% ability; no cues needed)	independent (91-100% ability; no cues needed)	
Cognition, Cognition	independent (no problems)	moderate (51-70% ability; frequent direction required in occasional situations)	minimal (81-90% ability; minimal problems, distractible)
Cognition, Orientation	person, facility, nursing/family, and time (x4)	person, place, and time (x3)	
Cognition, Recall	independent (no problems)	moderate (51-70% ability; frequent direction required in occasional situations)	minimal (81-90% ability; minimal problems, distractible)
Cognition, Safety-Judgement	independent (no problems)	moderate (51-70% ability; frequent direction required in occasional situations)	minimal (81-90% ability; minimal problems, distractible)
Cognition, Follow Commands	independent (no problems)	mild (71-80% ability; occasional direction needed, difficulty with memory)	

Speech Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
[redacted]	[redacted]			

PROVIDER NAME	PROVIDER NO.	MRN/ID
[redacted]	0010010003	

PHYSICIAN	PAYOR
Badalamenti, Linda (1073590865)	

MEDICAL DIAGNOSIS
S82.122D Displaced fracture of lateral condyle of left tibia, subsequent encounter for closed fracture with routine healing (07/01/2019)

TREATMENT DIAGNOSIS
R41.841 Cognitive communication deficit (07/07/2019)

START OF CARE 07/07/2019 **END OF CARE**

Underlying Impairments

Limb Dominance, Dominant Side
Right

Cognition, Alternating Attention
moderate (51-70% ability; frequent direction required in occasional situations)

Cognition, Complex Sequencing
moderate (51-70% ability; frequent direction required in occasional situations)

Cognition, Delayed Recall
marked (31-50% ability; frequent direction required in several situations)

Cognition, Executive Function
moderate (51-70% ability; frequent direction required in occasional situations)

Cognition, Mental Status
cooperative

Cognition, Problem Solving
moderate (51-70% ability; frequent direction required in occasional situations)

Cognition, Safety-Judgement
moderate (51-70% ability; frequent direction required in occasional situations)

Cognition, Sustained Attention
mild (71-80% ability; occasional direction needed, difficulty with memory)

Underlying Impairments Other
Impairments in

Standardized Tests
BCAT 36/50 indicating mild/moderate impairment, relative strengths in visual recall, abstraction, and story recall. Impairments in delayed recall, executive function, and attention tasks.

Goals	Goal Date
Cognition - Cognition (Cog Severity Scale scale): minimal (81-90% ability; minimal problems, distractible)	08/03/2019
STG: : Problem Solving- Complex: The patient will demonstrate simple problem solving for medication administration and home management tasks with stand by assist (supervision) and 10% verbal cueing with 100% accuracy in order to complete tasks independently upon return home	07/22/2019
Cognition - Recall (Cog Severity Scale scale): minimal (81-90% ability; minimal problems, distractible)	08/03/2019
STG: : COG-Attention : Patient will be able to attend to tasks for 90 seconds with 90% accuracy with no cues for ability to recall training sequences and new precautions related to mobility.	07/22/2019
STG: : General STG: Pt. Will peform recall of transfer sequences/steps with 50% accuracy and no verbal cues in order to complete safe transfers in current environment.	07/22/2019
Cognition - Safety-Judgement (Cog Severity Scale scale): minimal (81-90% ability; minimal problems, distractible)	08/03/2019
STG: : Follow Directions (TRIALS): The patient demonstrates the ability to follow 2 step directions in a multi stimulation environment with verbal instruction/cues for 8 / 10 trials in order to improve safety with functional mobility and IADLs.	07/22/2019

Rehab Potential: Excellent **due to:** Demonstrated higher functional level compared to current condition. Recent onset of medical condition. Responsive to cueing. Stable medical condition.

Informed Consent: Treatment plan, including benefits, risk and alternatives discussed with patient and/or family, who agree to treatment.

Patient Consent: Patient / Caregiver is aware and reports understanding of the diagnosis and prognosis.

Contraindications: No known contraindications.

Requires skilled services to focus on:

92507 - Speech therapy
92523 - Evaluation of speech sound production; with evaluation of language comprehension and expression

Frequency/Duration: 5 times a week for 4 weeks

Electronically Signed by Therapist: [redacted], ST **Date:** 07/08/2019

I agree, and it is my intent, to sign this record/document and affirmation of electronic signature for electronic submission and printed record/document. I understand that my signing and submitting this record/document in this fashion is the legal equivalent of having placed my handwritten signature on the submitted record/document and this affirmation.I understand and agree that by electronically signing and submitting this record/document in this fashion I am affirming to the truth of the information contained therein.

Speech Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
[redacted]	[redacted]			

PROVIDER NAME	PROVIDER NO.	MRN/ID
Smart Testing	0010010003	
PHYSICIAN Badalamenti, Linda (1073590865)	PAYOR	

MEDICAL DIAGNOSIS
S82.122D Displaced fracture of lateral condyle of left tibia, subsequent encounter for closed fracture with routine healing (07/01/2019)

TREATMENT DIAGNOSIS
R41.841 Cognitive communication deficit (07/07/2019)

START OF CARE 07/07/2019	END OF CARE

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Certification:
From 07/07/2019 To 08/03/2019

Physician Name: Badalamenti, Linda (1073590865)

☑ Signature Required

Physician Signature: ______________________ **Date:** ______________

I agree, and it is my intent, to sign this record/document, and I attest to the accuracy and authenticity of this electronic signature. I understand that submitting my signature in this fashion is the equivalent of having placed my handwritten signature on this record.