Extremities (UE):	Not assessed
Lower Extremities (LE):	B LE AROM: WFL EXCEPT FOR R KNEE: [illegible]TRENGTH: R HIP FLEXION: 3+/5, L HIP FLEXION: 3+/5, R KNEE EXTENSION: 3+/5, L KNE[illegible] 5/5, L ANKLE DF: 5/5

HEP Example in Clinical Note

Pain:

Intensity: 5 out of 10. **Location(s):** R knee

Aggravating Factors: R knee AROM **Relieving Factors:** rest, medication, cryotherapy

Instructions: Safety Measures, Pain Management, Positioning/Turning, Joint Protections, Edema Control, HEP, ADL(s), Fall Prevention/Recovery, Family/Caregiver Education, Proper Use of Equipment

Medication: There were **no changes** in medication.

Objective:
(Additional Information)

CARE COORDINATION: contacted RN case manager to discuss patient's plan of care; discussed the plan of care and discharge goals with the patient; pt. to be discharged when maximum benefit of physical therapy is achieved or all functional goals are met; performed home safety assessment; taught preventative and postural education strategies to reduce likelihood of secondary impairments and falls; and max. VCs to correct posture, gait and to complete her HEP. EDEMA: (RIGHT) LE 2+. And, THER EX Instructed, reviewed, performed and patient received the home exercise program today, which consisted of: SUPINE: B HEEL SLIDES, B HIP ABD, B QUAD SETS, B ANKLE DF/PF- all2 X 10 reps each. THER EX/HEP to be performed 2-3 times per day as well as PRICE x5 for 20 minutes with cryotherapy.

Problem Areas/Functional Limitations:

Decreased ROM, Impaired Functional Endurance, Impaired Functional Mobility, Dysfunctional Posture, Impaired Safety Awareness, Impaired Functional Strength, Dysfunctional Gait, Impaired Balance, Impaired Transfers, Fall Risk - PROBLEMS (cont): Decreased knowledge of HEP and Home Safety Precautions. PT ASSESSMENT: She is s/p RIGHT TKA. She presents to home health care after a long history of (RIGHT) knee pain and dysfunction. She presents with RIGHT KNEE pain with movements, edema as well as impaired gait, (RIGHT) knee AROM, standing posture and balance, R KNEE EXTENSION/R HIP FLEXION strength and a decreased ability to perform ADLs safely and independently. She is at HIGH fall risk. Her home P.T. prognosis is excellent for stated functional goals. Skilled home PT is indicated to address impairments, functional limitations and to reduce risk for falls and secondary impairments.

Goals:

STG	Patient to ambulate 100 ft. on Even surfaces w/ Rolling Walker assistive device and MI assist to ensure safe and functional ambulation (in 1 weeks from assessment).
LTG	Patient to ambulate 100 ft. on Both surfaces [illegible]t to ensure safe and functional ambulation (in 3 weeks from assessment).
LTG	Patient to climb up and down 8 steps with Stair Rails assistive device and I assist in order to safely enter/exit home for medical appointments (in 3 weeks from assessment).
STG	Patient to perform chair transfer(s) w/ MI assists using Rolling Walker assistive device in order to ensure safe functional transfer(s) (in 1 weeks from assessment).
LTG	Patient to perform bed transfer(s) w/ I assists using No assistive device in order to ensure safe functional transfer(s) (in 3 weeks from assessment).
LTG	Patient to demonstrate improvement in Tug score: from 26 sec to <14 sec in order to demonstrate decreased fall risk during functional mobility (in 3 weeks from assessment).
LTG	Patient to increase AROM of R knee to 0-105 to achieve safe household ambulation using no assistive device (in 3 weeks from assessment).
LTG	Patient to increase strength of R hip flexion/R knee extension to/by 1/2 MMT in order to be I assist using no assistive device to achieve Safe household ambulation (in 3 weeks from assessment).
STG	Patient will progress HEP supine/seated at each visit in order to be independent w/ home exercise program at discharge (in 1 weeks from assessment).
LTG	Patient will progress HEP standing/standing balance at each visit in order to be independent w/ home exercise program at discharge (in 3 weeks from assessment).
STG	Patient will demo Home Safety Precautions w/ I assist (in 1 weeks from assessment).

Rehab Potential/Progress Towards Goals: Excellent for stated functional mobility goals

D/C Planning/Planning for Next Visit: Pt. to be discharged when maximum benefit of home physical therapy is achieved or when all functional goals are met. She should be DC'ed to Out Patient physical therapy after MD follow up in 2-3 weeks.

Coordination Between Disciplines: The physical therapist contacted RN/case manager and discussed patient's plan of care and P.T. discharge goals.

Treatment as Tolerated (Basic POC): Pt and CG involved in development of goals and in agreement with POC, Evaluation, Therapeutic Exercise, Transfer Training, Establish Home Program, Gait Training, Stretching/Flexibility, Safety Training, Balance, Pain Modalities, Manual Therapy, Neuromuscular Re-Education, Pt/CG Training Education, Fall Risk