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Following the Patient Client Management module, patient care should be documented through the episode of care.

Initial Examination

History- The history of the examination is a collection of information which can be gathered through a patient/client or caregiver interview and includes a review of past and current medical and social information. The medical history may include pertinent medical diagnosis, surgical history, a list of current medications, information about previous clinical tests (X-rays, CT scan, etc) and a general review of current health status. The social history may include information on the patient / client's living environment, work status, and cultural preferences. In addition, it is recommended to include information on a patient / client's previous level of function.

Systems Review - A systems review is a necessary component of any initial examination. Information gathered from a systems review is imperative as it assists the physical therapist in determining conditions related and perhaps unrelated to the current chief compliant. In addition to a review of the various systems, this is a where information regarding a patient's / client's communication skills, cognitive abilities, and other important factors that might influence care or that is pertinent to function should be documented.

Teats and Measures - From the information gathered in the history and systems review, the physical therapist determines a hypothesis for a diagnosis. The physical therapist then determines which tests and measures are required to further prove (or disprove) the hypothesized diagnosis or diagnoses. In the documentation of tests and measures, a physical therapist should clearly identify the specific tests and measures, and any associated finding or outcome. In addition to traditional tests and measures (ROM, strength, balance, etc), more and more emphasis is placed on the importance of standardized tests and measures.

Evaluation – An evaluation is a thought process which leads to documentation of such items as impairments, functional limitations, and disabilities. This evaluation process is a synthesis of all of the data and findings gathered from the examination and should guide the physical therapist to a diagnosis and prognosis for each patient / client. The documentation of an evaluation can use formats such as a problem list or a statement of assessment with key factors (e.g., cognitive factors, co-morbidities, social support) influencing the patient/client status.

Disgricular — The disgrouss determined by the physical therapist after the evaluation process should be made at the impairment and functional limitation levels. It should identify the impact of a condition on function at the level of the system and the level of the whole person. The diagnosis by a physical therapist should be clearly documented and can take many formats. Some therapists choose to use common terminology to describe a diagnosis such as ICD coding or similar medical terminology. Another option is the Practice Patterns in the Guide to Physical Therapist Practice.

Prognosis - Documentation of the prognosis conveys the physical therapist's professional judgment for the patient / client's predicted functional outcome and the required duration of services to obtain this functional outcome.

Plan of Care - Documentation of the plan of care includes: 1) Overall goals stated in measurable terms that indicate the predicted level of improvement in function. Consider the expectation of the patient/client and others as appropriate; 2) A statement of interventions / treatments to be provided during the episode of care; 3) Proposed duration and frequency of service required to reach the goals; 4) Anticipated discharge plans

Re-examination- includes data from repeated or new examination elements and is provided to evaluate progress and to modify or redirect intervention. In general, a re-examination of a patient/client should occur whenever there is an unanticipated change in the patient's client's status, a failure to respond to physical therapy intervention as expected, the need for a new plan of care and / or time factors based on state practice act, or other requirements.

Visit / Encounter Notes — Can be referred to as daily notes. Document sequential implementation of the plan of care established by the physical therapist, including changes in patient/client status and variations and progressions of specific interventions used and man include: Patient / client or caregiver report; Interventions provided including frequency, intensity, and duration as appropriate: Patient/client response to treatments / interventions; Communication / collaboration with other providers/patient/client/tamily/ significant other; Factors that modify frequency or intensity of intervention and progression of goals; Plan for next visitis) including interventions with objectives, progression parameters and progressions; if indicated.

Discharge Summary – Documentation is required following conclusion, whether due to discharge or discontinuation of physical therapy services. The purpose of the discharge summary is to highlight a patient / client's progression towards goals and discharge plans. Essentially, this is the last time a therapist has to convey the outcome of physical therapy services. It is also the last opportunity to justify the medical necessity for the episode of care.

Tips for Documenting Evidence-Based Care 1) Keep up to date with ownent research through journal articles and reviews. Open Door, Hooked on Evidence at work acts one. 2) Continue to incorporate valid and reliable tests and measures as appropriate. 3) Include standardized tests and measures in your clinical documentation. 4) Review literature for evidence based interventions with APTA's Hooked on Evidence.

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AN Whitehead

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Writing Patient/Client Notes Ginge Kettenbach, Sarah Lynn Schlomer, Jill Fitzgerald, 2016-05-11 Develop all of the skills you need to write clear concise and defensible patient client care notes using a variety of tools including SOAP notes This is the ideal resource for any health care professional needing to learn or improve their skills with simple straight forward explanations of the hows and whys of documentation It also keeps pace with the changes in Physical Therapy practice today emphasizing the Patient Client Management and WHO's ICF model Sexual Assault Ouick-Reference Angelo P. Giardino, 2003 Sexual Assault Quick Reference is an invaluable resource and field guide in a convenient pocket sized format providing easy access to information for medical forensic and law enforcement investigations of sexual assault Color photos illustrate assault variants in multiple age groups from infants to the elderly Topics include the roles of multidisciplinary teams abusive and nonabusive variants physical and forensic evaluation procedures sexually transmitted infections STIs domestic violence DNA collection and testing disabled victims and preparing for prosecution This reference is especially helpful to first responders emergency room staff sexual assault nurse examiners social service agents and anyone else needing a concise guide to working with sexual assault victims **Documentation for Physical Therapist Assistants** Wendy D Bircher, 2017-10-01 Build your documentation skills and your confidence Step by step this text workbook introduces you to the importance of documentation shows you how to develop and write a proper and defensible note and prepares you to meet the technological challenges you ll encounter in practice You ll learn how to provide the proper documentation to assure all forms of reimbursement including third party for your services You ll also explore issues of patient confidentiality HIPAA requirements and the ever increasing demands of legal and ethical practice in a litigious society Nursing A Comprehensive Guide to Critical Care Nursing Practice Olivia Carter, 2025-11-23 Find all our resources on our platform created especially for nurses https ebookslibrary nursingcare com Discover the fast paced world of emergency care through the eyes of a UK emergency nurse Emergency Nursing The Essential UK Guide to Clinical Practice Triage and Critical Thinking in the ED is a comprehensive real world resource tailored for student nurses newly qualified staff and experienced practitioners working in or preparing for the Emergency Department A E Written by Olivia Carter a Senior Emergency Nurse Educator with over 15 years of NHS frontline experience this book goes beyond theory It bridges the gap between university learning and clinical reality offering readers vital tools in triage trauma care resuscitation paediatric emergencies mental health crisis response ethical practice and interprofessional teamwork Whether you re learning to prioritise with the Manchester Triage System navigating safeguarding in a busy ED interpreting ABGs or calculating paediatric drug doses this guide keeps you grounded in clinical best practice evidence based care and UK specific protocols Featuring Clear definitions of essential terms and acronyms NEWS2 ABCDE SBAR GCS Clinical case scenarios reflective questions and skills checklists Legal and ethical frameworks for mental health paediatrics and safeguarding Visual aids quick reference tables and end of chapter guizzes Ideal for nursing students Band 5 6 ED nurses clinical educators and advanced nurse practitioners seeking a solid foundation or a trusted companion on shift Pierson and Fairchild's Principles & Techniques of Patient Care - E-Book Sheryl L. 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