NOTE: This document is not all-inclusive and we strongly encourage all physical therapists and physical therapist assistants to review the Physical Therapy Statutes, Physical Therapy Administrative Rules and reference the Arizona State Board of Physical Therapy website.

Documentation Self-Assessment

GENERAL STATUTORY REQUIREMENTS All documents including, but not limited to, exercise flow sheets, home exercise/instruction **Bolded items are specifically identified in the AZ PT statutes and rules**	**Y**	**N**
Patient identification on each page		
Legible entries throughout		
All pages accurately dated		
All documents are signed according to state law		
Documentation of services accurate and must support billing		
Sufficient for another therapist to assume care without significant difficulty		
Documented compliance of general supervision PT/PTA requirements including license # of supervising PT and any consultation with PT (subject & decision)		
Co-signature for assistive personnel other than PTA		
Student Physical Therapist/Student Physical Therapist Assistant needs to be spelled out (no initials)		
Document advice or cautionary warning provided		
Errors corrected, initialed and dated – if EMR, appropriate reference to items corrected		
INITIAL EVALUATION – PHYSICAL THERAPIST ONLY	**Y**	**N**
Medical and treatment diagnosis		
Patient date of birth		
Informed consent for evaluation		
HISTORY AND SUBJECTIVE		
1. **Relevant medical history** showing review by therapist		
a. Major system review		
b. Includes all medication including OTC and vitamins/mineral supplements		
c. Vitals and hand dominance (if relevant)		
d. Includes all relevant past surgeries		
e. If referral for recent surgery, date of surgery, approach if appropriate		
f. For current issue, prior/current treatment and outcome		
g. Recent imaging, procedures, or laboratory studies if any		
2. Home environment and safety (steps, caregivers, etc.)		
3. **Reason for seeking PT services**		
4. **Current and chief complaints**		
a. Date of onset		
b. Nature of onset/mechanism of injury		
c. Prior/current functional status		
5. **Patient-stated/desired functional status goals**		
6. Patient report of pain		
7. Listing of any currently used assistive devices and efficacy of their use.		
OBJECTIVE		
1. System review as appropriate (many systems overlap)		
a. Musculoskeletal		
b. Neuromuscular		
c. Integumentary		
d. Somatosensory		
e. Cardiopulmonary		
f. Cognitive/perceptual		
2. Functional assessment/outcome tools (objective data from tests/measurements)		

INITIAL EVALUATION – PHYSICAL THERAPIST ONLY (Continued)	Y	N
<u>ASSESSMENT</u>		
Interpretation of the results of examination into a treatment diagnosis		
Precautions/contraindications		
Sufficient information to justify skilled need		
Prognosis		
Goals/Expected Outcomes – goals tied to function and time frame to achieve realistic outcomes		
Plan of Care – justification for therapeutic interventions (clinical rationale), and frequency and duration		
Informed consent for treatment		
Referral source communication within one week		
DAILY INTERVENTION NOTES	**Y**	**N**
<u>SUBJECTIVE</u>		
Status or response to treatment		
<u>OBJECTIVE</u>		
Interventions provided or supervised		
Objective data from tests/measurements if collected		
Instructions (if any) provided to patient		
Copies of all patient educational materials, instructions (i.e. home exercise program), and/or home treatment given		
<u>ASSESSMENT</u>		
Supportive functional and/or objective information that pertains to response to treatment		
Delegation (if any) to assistive personnel is documented on each DOS/qualifications of person to treat		
<u>PLAN</u> **Plan of care modifications if necessary – by Physical Therapist only**		
REEVALUATION/PROGRESS NOTES – PHYSICAL THERAPIST ONLY	**Y**	**N**
<u>SUBJECTIVE</u>		
Subjective report of current status		
The patient's current functional status/response to previous treatment(s)		
<u>OBJECTIVE</u>		
Objective data from tests and/or measurements, if collected		
<u>ASSESSMENT</u>		
Assessment of patient's progress		
Rationale for continuing therapeutic intervention		
<u>PLAN</u>		
Update in the plan of care if necessary		
DISCHARGE SUMMARY – PHYSICAL THERAPIST ONLY	**Y**	**N**
ACUTE CARE – last progress note by PT (if last note not by PT, PT D/C to include below)		
ALL OTHER SETTINGS: In addition to Progress Note format above:		
1. Date of discharge to episode of care		
2. Range of dates		
3. Total number of days treated in episode of care		
4. Reason why patient being discharged		
5. Current functional status		
6. Patient progress toward achieving goals in plan of care		
7. Discharge plan		
Referral source communication		