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

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 and include specified legal designation		
Documentation of services accurate and must support billing		
Documentation sufficient for another therapist to assume care of the patient/client at any time		
Documented compliance with general supervision PT/PTA requirements including name and license # of supervising PT, any consultation with the PT (subject and 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		
For each service date, the record of services provided and billed is accurate		
INITIAL EVALUATION – PHYSICAL THERAPIST ONLY	**Y**	**N**
Medical diagnoses or conditions, 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, **signs and symptoms**		
a. Date of onset		
b. Nature of onset/mechanism of injury		
c. Prior/current functional status include use of assistive devices as relevant		
5. Patient-stated desired functional status/goals		
6. Patient report of pain		
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
ASSESSMENT		
Interpretation of the results of examination (should relate to treatment diagnosis, if required)		
Precautions/contraindications		
Justification of the planned intervention and of skilled need		
Plan of Care – 1. **Measurable goals** (tied to function) 2. **Interventions (must include clinical rational for the planned intervention(s) as noted above** 3. **Frequency and duration** (duration should be timeframe to achieve realistic outcomes)		
Prognosis		
Informed consent for treatment		
Referral source communication within one week of initial evaluation		
DAILY INTERVENTION NOTES (written by individual(s) who provided service)	**Y**	**N**
SUBJECTIVE		
Patient report of current status or response to treatment		
OBJECTIVE -		
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		
ASSESSMENT – Supportive functional and/or objective information that pertains to response to treatment, supports skilled intervention		
Determination if appropriate to delegate to assistive personnel is done by the licensed PT on *each date of service*, should be documented, **and is based upon patient acuity/treatment plan, qualifications of person to treat, level of expertise needed**		
PLAN – Plan of care modifications if necessary (by Physical Therapist only)		
REEVALUATION/PROGRESS NOTES – PHYSICAL THERAPIST ONLY	**Y**	**N**
SUBJECTIVE		
1. Subjective report of current status		
2. The patient's response to previous treatment(s)		
OBJECTIVE		
1. Objective data from tests and/or measurements, if collected		
2. Current functional status		
ASSESSMENT		
3. Assessment of patient's progress		
4. Rationale for continuing therapeutic intervention		
PLAN		
1. 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		