PATIENT’S CHIEF COMPLAINT AND DURATION

______________________________________________________________________________________________________________

HISTORY OF PRESENT ILLNESS
☐ Refer to Preadmission Assessment Form
Modifications to and/or additions to Preadmission Assessment Form: _____________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
                                                                                                           
______________________________________________________________________________________________________________

PAST MEDICAL AND SURGICAL HISTORY
☐ Refer to Preadmission Assessment Form
Modifications to and/or additions to Preadmission Assessment Form: ______________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
                                                                                                           
______________________________________________________________________________________________________________

DIET
☐ Refer to Preadmission Assessment Form
Modifications to and/or additions to Preadmission Assessment Form: ______________________________________________________
                                                                                                           
ALLERGIES
☐ Refer to Preadmission Assessment Form
Modifications to and/or additions to Preadmission Assessment Form: ______________________________________________________
                                                                                                           
TRANSFER MEDICATION
☐ See Medication Reconciliation Order Form
☐ Medication Reconciliation Order Form Reviewed

SOCIAL HISTORY AND PRIOR LEVEL OF FUNCTION
☐ Refer to Preadmission Assessment Form
Modifications to and/or additions to Preadmission Assessment Form: ______________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
                                                                                                           
______________________________________________________________________________________________________________
**FAMILY HISTORY**

- Cancer
- Cerebrovascular Accident
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Dementia
- Diabetes Mellitus
- Hyperlipidemia
- Hypertension
- Myocardial Infarction
- Other: ____________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**CURRENT FUNCTIONAL STATUS**

- Refer to Preadmission Assessment Form

Modifications to and/or additions to Preadmission Assessment Form: __________________

______________________________________________________________________________

**LABORATORY STUDIES AND/OR DIAGNOSTIC TESTS** (Document pertinent studies and/or tests)

- Refer to Preadmission Assessment Form for details

Modifications to and/or additions to Preadmission Assessment Form: __________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Lab/Test/Procedure</th>
<th>Result(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hemoglobin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>White Blood Cell Count</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Platelets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>INR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sodium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potassium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glucose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BUN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Creatinine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Magnesium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SGPT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SGOT</td>
<td></td>
</tr>
</tbody>
</table>

Imaging studies and/or other diagnostic studies (specify): __________________

______________________________________________________________________________

______________________________________________________________________________

**REVIEW OF SYSTEMS**

- The 13 major systems were reviewed. All were negative except for the following: __________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
**PHYSICAL EXAM (Check all that apply, include any additional information, and provide a narrative explanation)**

**Constitutional**
- Temperature: Oral ◯ C ______________
- Heart rate: __________________ beats per minute
- Respiratory Rate: __________________ per minute
- Blood Pressure: _________/_________ mmHg
- Height: _____________ cm and/or________________ inches
- Weight: ______________ kg and/or________________ pounds
- General Appearance:

**Head, Eyes, Mouth and Throat**

**Head/Face**
- Normal
- Traumatic
- Atraumatic
- Symmetric
- Asymmetric
- Cranial Nerves: ◯ Normal ◯ Abnormal (describe)

**Eyes**
- Pupils: ◯ Normal ◯ Equal ◯ Unequal ◯ Reactive ◯ Non-reactive
- Vision: ◯ Normal ◯ Abnormal: ◯ Poor visual acuity
- Diplopia ◯ Homonymous hemianopsia

**Mouth/Throat**
- Dentition: ◯ Normal ◯ Dentures
- Supple ◯ Restrictive

**Neck**
- Supple ◯ Restrictive

**Heart/Lungs**
- Rhythm: ◯ Regular ◯ Irregular
- Respiratory effort: ◯ Normal ◯ Abnormal
- Refer to Internal Medicine and/or Cardiology

**Abdomen**
- Normal ◯ Soft ◯ Firm ◯ Scaphoid

**Upper Extremities/Upper Body Exam (also refer to Nursing Skin and Wound Assessment)**

<table>
<thead>
<tr>
<th>Edema</th>
<th>Normal</th>
<th>+1</th>
<th>+2</th>
<th>+3</th>
<th>+4</th>
<th>Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulses</td>
<td>Normal</td>
<td>Abnormal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>Normal</td>
<td>Abnormal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Decubitus Ulcer/Ulcerations: ◯ No ◯ Yes/location: ____________________________

Deformities: ◯ No ◯ Rheumatoid arthritis changes ◯ Osteoarthritis changes ◯ Other (list)
Lower Extremities/Lower Body Exam (also refer to Nursing Skin and Wound Assessment)

Edema: □ None □ +1 □ +2 □ +3 □ +4
Location: _________________________________________________________________

Pulses: □ Normal □ Abnormal

Skin: □ Normal □ Abnormal

Decubitus Ulcer/Ulcerations: □ No □ Yes/location:__________________________________________________________

Neurological/Musculoskeletal

Mentation: □ Alert □ Drowsy □ Lethargic
Orientation: □ Self □ Place □ Time □ Circumstance
Speech and Language: □ Normal □ Fluent □ Nonfluent
Comprehension: □ Normal □ Abnormal
Expression: □ Normal □ Abnormal
Memory: Short Term: □ Normal □ Abnormal
Perceptual: □ Normal □ Field cuts □ Neglect □ Gaze palsy □ Right-Left discrimination □ Agnosia □ Apraxia
□ Spatial relations deficit □ Other/list

If above abnormal, provide a narrative explanation of findings:
______________________________________________________________________________________________________________

Muscle tone: □ Normal □ Hypertonic/spastic □ Hypotonic/flaccid □ Rigid □ Cogwheel □ Spasms □ Atrophy
□ Generalized intrinsic atrophy: Hands/Feet □ Other/list

Characteristics of Movement: □ Normal □ Dysmetria □ Intention tremors □ Resting tremors □ Ataxia □ Apraxia
□ Postural/static tremors □ Bradykinesia □ Rigidity □ Akinesia □ Chorea/athetosis □ Fasiculation
□ Impaired coordination □ Impaired dexterity □ Other/list

Manual Muscle Test/Range of Motion

<table>
<thead>
<tr>
<th>Upper Extremity</th>
<th>Proximal</th>
<th>Distal</th>
<th>Range of Motion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>/5</td>
<td>/5</td>
<td>□ WFL □ Impaired: Proximal Distal □ Limited due to strength: Proximal Distal</td>
</tr>
<tr>
<td>Left</td>
<td>/5</td>
<td>/5</td>
<td>□ WFL □ Impaired: Proximal Distal □ Limited due to strength: Proximal Distal</td>
</tr>
</tbody>
</table>
Physical Medicine and Rehabilitation
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AFFIX PATIENT LABEL HERE
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Manual Muscle Test/Range of Motion

<table>
<thead>
<tr>
<th>Lower Extremity</th>
<th>Proximal</th>
<th>Distal</th>
<th>Range of Motion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>/5</td>
<td>/5</td>
<td>☐ WFL ☐ Impaired: Proximal Distal ☐ Limited due to strength: Proximal Distal</td>
</tr>
<tr>
<td>Left</td>
<td>/5</td>
<td>/5</td>
<td>☐ WFL ☐ Impaired: Proximal Distal ☐ Limited due to strength: Proximal Distal</td>
</tr>
</tbody>
</table>

Sitting balance: ☐ Good ☐ Fair ☐ Poor
Standing balance: ☐ Good ☐ Fair ☐ Poor
Reflexes (insert symbol): ☐ Depressed Deep Tendon Reflexes
☐ Abnormal Nerve Tension Signs: ____________________________
☐ Abnormal Reflexes (describe): ____________________________

<table>
<thead>
<tr>
<th>Sensation</th>
<th>Upper Extremity</th>
<th>Lower Extremity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right</td>
<td>Left</td>
</tr>
<tr>
<td>Light Touch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pin Prick</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proprioception</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Comments: __________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

ASSESSMENT AND INDIVIDUALIZED PLAN OF CARE

Primary Rehab Impairment: ☐ Refer to Preadmission Assessment Form Other: ____________________________
Diagnosis: ☐ Refer to Preadmission Assessment Form Other: ____________________________

If impairment and/or diagnosis different than the Preadmission Form, please provide a narrative explanation as to why:
_______________________________________________________________________________
_______________________________________________________________________________

Etiology of Impairment (Specify anatomical location and mechanism of pathology):
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

HFH 012 (11/2012) MEDICAL RECORD COPY History and Physical
Secondary and Related Diagnoses based on the Rehab Impairment (sequelae of above)

1. ____________________________________________________________________________________________________________
2. ____________________________________________________________________________________________________________
3. ____________________________________________________________________________________________________________
4. ____________________________________________________________________________________________________________
5. ____________________________________________________________________________________________________________
6. ____________________________________________________________________________________________________________
7. ____________________________________________________________________________________________________________
8. ____________________________________________________________________________________________________________

Active Comorbidities upon Admission

Refer to Preadmission Assessment Form

 Modifications to and/or additions to Preadmission Assessment Form:

1. ____________________________________________________________________________________________________________
2. ____________________________________________________________________________________________________________
3. ____________________________________________________________________________________________________________
4. ____________________________________________________________________________________________________________
5. ____________________________________________________________________________________________________________
6. ____________________________________________________________________________________________________________
7. ____________________________________________________________________________________________________________
8. ____________________________________________________________________________________________________________

Medical Plan and Reasoning

1. ____________________________________________________________________________________________________________
2. ____________________________________________________________________________________________________________
3. ____________________________________________________________________________________________________________
4. ____________________________________________________________________________________________________________
5. ____________________________________________________________________________________________________________
6. ____________________________________________________________________________________________________________
7. ____________________________________________________________________________________________________________
8. ____________________________________________________________________________________________________________
9. □ Pain Management:
10. □ Deep Vein Thrombosis Prophylaxis:
11. □ Diabetes Management:
12. □ Hypertension Management:
13. □ Pulmonary Hygiene Management:
14. □ Nutrition Management:
15. □ Pressure Ulcer Management:
PROOF

Physical Medicine and Rehabilitation
History and Physical, Post-Admission Assessment and Plan of Care
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IMPAIRMENT—Problems in body organ or structure (Please correlate to the History and Physical assessment)

☐ Abnormal reflexes ☐ Endurance ☐ Pressure ulcers
☐ Aphasia ☐ Hemiparesis/plegia ☐ Quadraparesis/plegia
☐ Apraxia ☐ Higher-level language deficits ☐ Sensory loss
☐ Ataxia ☐ Incontinence ☐ Shortness of breath
☐ Clonus ☐ Joint contractures/deformities ☐ Spasticity
☐ Cognition ☐ Neurogenic bladder ☐ Speech impairments
☐ Coordination ☐ Neurogenic bowel ☐ Swallowing difficulties
☐ Dysarthria ☐ Non-healing wound ☐ Visual deficits
☐ Dysfluency ☐ Pain ☐ Voice disturbances
☐ Dysphagia ☐ Paraparesis/plegia ☐ Weakness
☐ Edema ☐ Phantom limb pain/sensation ☐ Other (list)

ACTIVITY LIMITATIONS (PERSON DOMAIN) Difficulties an individual may have in executing a task or action

☐ Ambulation ☐ Diabetes management ☐ Residual limb care/management
☐ Balance ☐ Dressing ☐ Safety awareness
☐ Bathing ☐ Eating ☐ Skin/wound care
☐ Bed mobility ☐ Grooming ☐ Stair management
☐ Bed transfers ☐ Intravenous antibiotics management ☐ Toilet transfers
☐ Bowel management ☐ J-tube/PEG tube management ☐ Toileting
☐ Car transfers ☐ Meal preparation ☐ Tub transfers
☐ Chair transfers ☐ Medical management ☐ Weightbearing status
☐ Congestive heart failure management ☐ Medication management ☐ Wheelchair mobility
☐ Endurance ☐ Pressure ulcer prevention ☐ Other (list)

PARTICIPATION LIMITATIONS (SOCIAL DOMAIN) Problems an individual may experience in involvement in life situations

The patient is unable to mobilize outdoors, go shopping, attend community events, and enjoy active leisure interests.

Other (student, working, caring for others):

BARRIERS TO DISCHARGE

☐ Accessibility of home ☐ Intravenous antibiotics
☐ Amount of physical assistance required for functional activities ☐ Lack of caregiver support
☐ Bladder management ☐ Medication management
☐ Bowel management ☐ Multiple medically complex conditions that may be difficult to manage by caregiver and/or patient
☐ Cognition ☐ Pain
☐ Congestive heart failure management ☐ Parenteral feedings
☐ Diabetes management ☐ Poor safety awareness
☐ Difficulty or inability to manage a curb step or stairs ☐ Sensory deficits
☐ Difficulty following/maintaining precautions or restrictions ☐ Tracheostomy care
☐ Dysphagia ☐ Tube feedings
☐ Endurance ☐ Visual deficits
☐ High risk for falls if left unsupervised ☐ Weakness
☐ Home alone ☐ Weightbearing status
☐ Incontinence ☐ Wound and/or skin care management

HFWH 012 (11/2012) MEDICAL RECORD COPY History and Physical
Physical Medicine and Rehabilitation
History and Physical, Post-Admission Assessment and Plan of Care
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REHABILITATION PLAN
The patient is being admitted to a comprehensive acute inpatient rehabilitation program consisting of at least 3 hours of combined physical and occupational therapy 5 out of 7 days per week, 24-hour skilled rehabilitation nursing care, and close supervision of a physician with specialized training and experience in rehabilitation medicine. The patient’s prognosis for significant practical improvement within a reasonable period of time appears _____________. The estimated length of stay is ________ days, and he/she is expected to be able to return ____________ with ___________________ and outpatient or home health care services. Inpatient rehabilitation services are indicated based on the patient’s complex condition(s) and risk for further medical complications. Rehabilitation services, as indicated above, could not be safely provided at a lower level of care such as a skilled nursing facility or long term care facility.

REHABILITATION INTERVENTIONS
(Please check off appropriate disciplines, circle pertinent treatment interventions, and document hours/day, days/week, and duration where services are indicated)

☐ 24-HOUR REHABILITATION NURSING (circle): for bowel and bladder management, skin care, wound care, pressure ulcer prevention, medication management, monitor medical complications and risk factors, provide patient/family/caregiver education and training, nutritional management, carry-over of functional activities on the nursing unit, and safety awareness.

☐ PHYSICAL THERAPY (circle): for therapeutic exercise, muscle re-education, balance activities, bed mobility, transfer techniques, gait training, wheelchair mobility, stair management, durable medical equipment recommendations and education, orthotic/prosthetic management as appropriate, and patient/family/caregiver education and training.

Hours/day=_______________ Days/week=________________ Duration=_________________ days

☐ OCCUPATIONAL THERAPY (circle): for therapeutic exercise, muscle re-education, activities of daily living, transfer techniques, bed mobility, durable medical equipment recommendations and education, and patient/family/caregiver education and training.

Hours/day=_______________ Days/week=________________ Duration=_________________ days

☐ SPEECH THERAPY (circle): for dysphagia, swallowing, higher level language deficits, dysarthria, aphasia, apraxia, visual neglect, voice, dysfluency, neurogenic dysfluency, right hemisphere disorder, and patient/family/caregiver education and training.

Hours/day=_______________ Days/week=________________ Duration=_________________ days

☐ SOCIAL WORK: for discharge planning, coordination of post-acute care services, family liaison, and emotional support.

☐ NEUROPSYCHOLOGY SERVICES: for assessment of neurocognitive abilities to assist with treatment and discharge planning and/or psychotherapeutic intervention to address emotional and/or behavior issues.

☐ RECREATIONAL THERAPY: for community re-entry education and treatment oriented activity focusing on physical, social, cognitive, and emotional functioning.

☐ DIETARY SERVICES: for nutrition assessment and patient/family nutrition education and training.

☐ CHAPLIN SERVICES: offer spiritual belief and practices support

☐ OTHER: _________________________________________________
REHABILITATION FUNCTIONAL OUTCOMES (minimum first 11 should be included)

- Activities of Daily Living: Increase independence in activities of daily living
- Ambulation: Ability to ambulate with a device household to community distances
- Community reintegration: Ability to mobilize in a community setting
- Durable Medical Equipment: Patient aware of durable medical equipment needs
- Education: Patient, family, and/or caregiver education
- Home Environment: Patient safe in the home environment
- Medical and Functional: Optimize the patient’s ability to benefit from the rehabilitation program
- Medical: Management of active comorbidities affecting functional recovery and prevention of further complications
- Medication: Ability to manage medications
- Safety: Improve overall safety awareness
- Bladder: Bladder management and control
- Bowel: Bowel management and control
- Cognition: Improve cognitive function
- Communication: Improve communication skills
- Curb step and/or stairs: Ability to manage with or without a device and/or assistance
- Durable Medical Equipment: Obtain/recommend durable medical equipment
- Home Environment: Home modifications as needed
- Infection: Infection prevention
- Infection: Patient aware of signs and symptoms of infection
- Leisure: Physical leisure skills improvement
- Medical: Able to perform Accuchecks safely
- Medical: Ability to monitor daily weights at home
- Medical: Patient awareness of hypoglycemia and/or hyperglycemia symptoms
- Medical: Patient awareness of worsening signs of congestive heart failure
- Medication: Ability to manage intravenous antibiotics
- Nutrition: Ability to achieve optimal diet consistency
- Nutrition: Ability to manage tube feedings
- Nutrition: Increase nutrition knowledge as related to the individual care plan
- Nutrition: Meet protein and/or caloric recommendations based on the nutritional assessment
- Nutrition: Patient aware of dietary requirements
- Orthotic and/or prosthetic management
- Pain: Managed pain control
- Precautions/Restrictions: Able to verbalize precautions/restrictions related to diagnosis
- Range of motion, strength and coordination lower extremities: Increase in lower extremities
- Range of motion, strength and coordination upper extremities: Increase in upper extremities
- Skin: Wound healing without signs and symptoms of infection
- Skin: Patient and/or family able to manage wound/skin care
- Weightbearing Status: Able to verbalize weight-bearing status
- Wheelchair: Ability to manage armrests, legrests and brakes prior to mobility
- Wheelchair: Ability to propel wheelchair household to community distances
- Other:___________________________________________________________________________________________________

___________________________________________________________________________________________________

___________________________________________________________________________________________________

Physician Signature ___________________________ Date _____________ Time _____________