Documentation Review Sample Checklist

APTA
American Physical Therapy Association
The Science of Healing. The Art of Caring.

REVIEW FOR MEDICAL RECORDS DOCUMENTATION

Physical Therapy

Note: This is meant to be a sample documentation review checklist only. Please check payer, state law, and specific accreditation organization (i.e., Joint Commission, CARF, etc) requirements for compliance.

Therapist reviewed: Privileged and Confidential

PT Initial Visit Elements for Documentation Date:	N/A	Yes	No
Examination:			
1. Date/time 2. Legibility			
3. Referral mechanism by which physical therapy services are initiated			
4. History – medical history, social history, current condition(s)/chief complaint(s), onset, previous functional status and activity level, medications, allergies			
5. Patient/client's rating of health status, current complaints			
6. Systems Review – Cardiovascular/pulmonary, Integumentary, Musculoskeletal, Neuromuscular, communication ability, affect, cognition, language, and learning style			
7. Tests and Measures – Identifies the specific tests and measures and documents associated findings or outcomes, includes standardized tests and measures, e.g., OPTIMAL, Oswestry, etc.			
Evaluation:			
1. Synthesis of the data and findings gathered from the examination: A problem list, a statement of assessment of key factors (e.g., cognitive factors, co- morbidities, social support, additional services) influencing the patient/client status.			
Diagnosis:			
1. Documentation of a diagnosis - include impairment and functional limitations which may be practice patterns according to the Guide to Physical Therapists Practice, ICD9-CM, or other descriptions.			
Prognosis:			
1. Documentation of the predicted functional outcome and duration to achieve the desired functional outcome			
Plan of Care:			
1. Goals stated in measurable terms that indicate the predicted level of improvement in function			
2. Statement of interventions to be used; whether a PTA will provide some interventions			
3. Proposed duration and frequency of service required to reach the goals (number of visits per week, number of weeks, etc)			
4. Anticipated discharge plans			
Authentication:			
1. Signature, title, and license number (if required by state law)			

PT Daily Visit Note Elements for Documentation Date:	N/A	Yes	No
1. Date			
2. Cancellations and no-shows			
3. Patient/client self-report (as appropriate) and subjective response to previous treatment			
4. Identification of specific interventions provided, including frequency, intensity, and duration as appropriate			
5. Changes in patient/client impairment, functional limitation, and disability status as they relate to the plan of care.			
6. Response to interventions, including adverse reactions, if any.			
7. Factors that modify frequency or intensity of intervention and progression toward anticipated goals, including patient/client adherence to patient/client-related instructions.			
8. Communication/consultation with providers/patient/client/family/ significant other.			
9. Documentation to plan for ongoing provision of services for the next visit(s), which is suggested to include, but not be limited to: The interventions with objectives Progression parameters Precautions, if indicated			
10. Continuation of or modifications in plan of care			
11. Signature, title, and license number (if required by state law)			

PT Progress Report Elements for Documentation ** Date:	N/A	Yes	No
1. Labeled as a Progress Report/Note or Summary of Progress 2. Date			
3. Cancellations and no-shows			
4. Treatment information regarding the current status of the patient/client			
5. Update of the baseline information provided at the initial evaluation and any needed reevaluation(s)			
6. Documentation of the extent of progress (or lack thereof) between the patient/client's current functional abilities/limitations and that of the previous progress report or at the initial evaluation			
7. Factors that modify frequency or intensity of intervention and progression toward anticipated goals, including patient/client adherence to patient/client-related instructions.			
8. Communication/consultation with providers/patient/client/family/ significant other			
9. Documentation of any modifications in the plan of care (i.e., goals, interventions, prognosis)			
10. Signature, title, and license number (if required by state law)			

** The physical therapist may be required by state law or by a payer, such as Medicare, to write a progress report. The daily note is not sufficient for this purpose unless it includes the elements listed above.

PT Re-examination Elements for Documentation Date:	N/A	Yes	No
1. Date			
2. Documentation of selected components of examination to update patients/client's impairment, function, and/or disability status.			
3. Interpretation of findings and, when indicated, revision of goals.			
4. Changes from previous objective findings			
5. Interpretation of results			
6. When indicated, modification of plan of care, as directly correlated with goals as documented.			
7. Signature, title, and license number (if required by state law)			

PT Discharge/Discontinuation/Final Visit Elements for Documentation Date: Note: discharge summary must be written by the PT and may be combined with the final visit note if seen by the PT on final visit	N/A	Yes	No
1. Date			
2. Criteria for termination of services			
3. Current physical/functional status.			
4. Degree of goals and outcomes achieved and reasons for goals and outcomes not being achieved.			
5. Discharge/discontinuation plan that includes written and verbal communication related to the patient/client's continuing care.			
6. Signature, title, and license number (if required by state law)			

PTA Visit Note Elements for Documentation Date:	N/A	Yes	No
1. Date			
2. Cancellations and no-shows			
3. Patient/client self-report (as appropriate) and subjective response to previous treatment			
4. Identification of specific interventions provided, including frequency, intensity, and duration as appropriate			
5. Changes in patient/client impairment, functional limitation, and disability status as they relate to the interventions provided.			
6. Subjective response to interventions, including adverse reactions, if any			
7. Continuation of intervention(s) as established by the PT or change of intervention(s) as authorized by PT			
8. Signature, title, and license number (if required by state law)			