Santa Clara Family Health Plan™

Weekly Therapy Update

Please complete and fax to SCFHP at **1-408-874-1957** or **1-408-376-3548** for weekly review.

Member Name:____________________ Facility:____________________

ID Number:____________________ Contact Person:____________________

Admission Date:____________________ Phone Number:____________________

Diagnosis:____________________ Today's Date:____________________

Physical Therapy

Frequency:__________days per week. Pain level:_______/10

Balance: ☐ Good ☐ Fair ☐ Poor Endurance: ☐ Good ☐ Fair ☐ Poor ☐ Improve ☐ Decrease

AD Use: ☐ FFW ☐ WC ☐ Cane ☐ Walker ☐ Other:____________________

Sit/Stand	☐ Max A	☐ Mod A	☐ Min A	☐ CGA	☐ SBA	☐ Verbal Cues	☐ Independent
Pivot Transfer	☐ Max A	☐ Mod A	☐ Min A	☐ CGA	☐ SBA	☐ Verbal Cues	☐ Independent
Ambulation	☐ Max A	☐ Mod A	☐ Min A	☐ CGA	☐ SBA	☐ Verbal Cues	☐ Independent

PT additional notes/Barriers to DC:____________________

Occupational Therapy

Frequency:__________days per week Pain level:_______/10

Grooming	☐ Max A	☐ Mod A	☐ Min A	☐ CGA	☐ SBA	☐ Modified Ind	☐ Independent
UE dressing	☐ Max A	☐ Mod A	☐ Min A	☐ CGA	☐ SBA	☐ Modified Ind	☐ Independent
LE dressing	☐ Max A	☐ Mod A	☐ Min A	☐ CGA	☐ SBA	☐ Modified Ind	☐ Independent
Bathing	☐ Max A	☐ Mod A	☐ Min A	☐ CGA	☐ SBA	☐ Modified Ind	☐ Independent
Toileting	☐ Max A	☐ Mod A	☐ Min A	☐ CGA	☐ SBA	☐ Modified Ind	☐ Independent
Bed Mobility	☐ Max A	☐ Mod A	☐ Min A	☐ CGA	☐ SBA	☐ Modified Ind	☐ Independent

OT additional notes/ Barriers to DC:____________________

Speech Therapy

Frequency:__________days per week. Pain level:_______/10

Current diet: ☐ NPO ☐ Clear Liquid ☐ Soft Mech ☐ Regular ☐ Tube feeding

Swallowing:____________________

Language:____________________

ST additional notes/Barriers to DC:____________________

Skills Needs

☐ IV therapy ____________________ ☐ TPN/Lipids

☐ Tube Feeding ____________________ ☐ Wound care treatment ____________________

Location:__________ Type:__________ Dressing change:________ times per ________

RN notes/ Barriers to DC:____________________

Scheduled Appt with Specialist:____________________ Date:__________ Time:__________

Transportation level ☐ Wheelchair ☐ Gurney ☐ Ambulance BLS ☐ Ambulance ALS ☐ Bariatric

MANDATORY: TO BE COMPLETED WITH WEEKLY UPDATES

Anticipate discharge (DC) date ______________ to ☐ Home ☐ ALF ☐ LTC ☐ Hospice ______________

Anticipate DC needs: Home care services: ☐ SNV ☐ HHA ☐ PT ☐ OT ☐ ST ☐ Home Infusion

☐ DME ____________________

Transportation required at DC: ☐ Family ☐ Wheelchair ☐ Gurney ☐ Bariatric

Home evaluation scheduled on __________ ☐ Expired on ______________

☐ Transferred date ______________ to ☐ Hospital ______________ ☐ SNF ______________