Clinical Summary Example

Patient's Name

CLINICAL JUSTIFICATION SUMMARY

This is a 70 y/o male, with a history of DM who underwent left total hip placement on 3/1/16 and has a chronic DM wound on the left foot. Pt was transferred to SNF for rehab from 3/5-4/5/16. Patient was referred to home health PT and SN. Patient was evaluated by PT and SN to initiate care on 4/7/16, physician order requesting *7 PT visits and 4 SN visits in a 60 day period.*

Current status from PT:

1. Lives with wife in 2-story house home bound due to stairs and unsteady gait.
2. Ambulates with FFW 15feet with min verbal and tactile cues to decrease distance between self and walker, managing walker in proper direction and speed.
3. Minimum assist sit to stand from wheelchair
4. Minimum assist transfers
5. Sit to supine: maximum assist

Current Status of wound:

1. Slow healing DM ulcer on left medial metatarsal head, surgically debrided during hospitalization.

Treatment Plan and Goal:

1. Home PT will continue treatment to train patient and care giver on fall prevention, proper body mechanics, progressive ROM strengthening and balance exercises, HEP, pain management, equipment usage.
2. SN reported bilateral 2+ edema, will teach care giver to wrap and ted hose 2x a week.
3. Promogran Prisma matrix moistened with hydrogel, cover with silver foam and secure with Kerlix to be changed every 2-3 days. Skilled Nurse will educate wife on dressing changes
4. SN is required to assess wound healing, and monitor for infection
5. Patient's next WCC visit is 5/20/16.

PRINTED NAME AND SIGNATURE

Print Name

Signature