

PhysicalTherapyEvaluationForms.com

~ Documentation Made Easy ~



Frequently Asked Questions (FAQ) Please Read Before Using

1. Why were these forms developed?

The forms were created to ensure a complete, quality evaluation by a physical therapist [PT], producing a product that was easy to read for clinicians, physicians, referral sources, and insurance companies.

2. What steps are eliminated in using these forms?

Trying to remember all of the appropriate questions and special tests for each body area are the biggest; the questions you need to ask are right there. Writing is eliminated, and more importantly, the need for transcription work.

3. When the PT is finished with the objective portion of the evaluation, what else has to be completed?

Typographical errors need to be corrected. A treatment plan, short and long term goals, frequency of care, and impression need to be added. And it needs to be printed and signed.

4. Is there a certain population of PTs who excel at using PTEF?

People who are more computer literate or are at least comfortable with their typing skills do much better with PTEF. In this manner, many new graduates very much enjoy working with these forms. However, as PTs become more familiar with the format, it becomes easier and quicker to complete the form and to correct typographical errors during the evaluation versus after the fact, decreasing time until completion.

5. Is there a learning curve?

As with any tool, there is a learning curve. The forms were designed primarily for an outpatient orthopedic physical therapy setting. The PT will need to make themselves familiar with the forms and tests to be able to efficiently complete them. Due to the wide variety of evaluations that PTs can perform, the numerous drop-down lists can be saved with whatever answer the PT feels is the most common answer. For example, one of the subjective questions on the evaluation is asking the patient if they have fallen in the last year; this question was added in response to CMS's [Centers for Medicare & Medicaid Services] addition of the PQRI [Physician's Quality Reporting Initiative]. The PT can decide to save the template with 'yes' or 'no' saved as the primary answer. Similarly, on the low back and hip evaluation form, if the PT does not typically evaluate hip abduction or extension, then these can be saved as 'not tested', including changing the degree sign to a blank space. Measurements and degrees can be added as needed.

6. What else needs to be added to the forms to complete the evaluation?

The forms are meant to be all inclusive. There is even a place for a PT signature and a signature of the referral source, so the treatment plan can be appropriately approved.

7. What else can be done to hasten the evaluation process?

The PT should take the time to customize the form with their preferences to make completing the evaluation as time-efficient as possible. The forms then need to be saved in this format.

8. Can the forms be used over and over again?

They certainly are meant to be used over and over. All of the forms should be saved on a CD and/or copied to another folder, both initially and once the customization has been completed. Once inputting patient information, it is STRONGLY advised that the document be saved by patient name [and date], in another specific folder. In our experience, it has worked best to input the patient's name on the form and immediately save the file by another name. Then, during the evaluation, the PT can click on <save> to quickly save the file. If you do not do this and inadvertently save John Doe's back initial evaluation as 'LB IE', then the next time you need the low back evaluation form, you would need to use your back-up file or delete all of the information from the form to start with a clean slate again.

9. If the forms are all inclusive, then can't anyone use the forms to evaluate themselves or other disciplines use the forms?

The PT must still use his/her knowledge base to determine the best tests to perform, or if certain tests are not necessary. For example, on the low back and hip evaluation form, the PT needs to determine if all of the ROM testing is necessary; if so, there is a place to document findings. However, there is also a place to document 'not tested'. Similarly, some common tests are listed on the form but there are also blank text blocks to allow for the addition of supplementary testing; this is especially probable on the specialized hand form. There is a blank text block at the end of every section, to allow for further customization. Most importantly, the PT must also use their knowledge base to develop a treatment plan, goals, and assessment.