CHAPTER 9

Interprofessional Communication

CHAPTER OBJECTIVES

1. Determine what communications with a patient or client or caregiver should be documented in the health record.
2. Determine how and where to document verbal or electronic communications with a patient or client or caregiver outside the context of a scheduled encounter.
3. Recognize how to document the results of a verbal or electronic consultation or inquiry with a healthcare provider on behalf of your patient or client.
4. Recognize how to document requests for documents from other healthcare providers on behalf of your patient or client such as operative reports, imaging results, or referrals.
5. Recognize the components required to create a letter of medical necessity for durable medical equipment.

KEY TERMS

Electronic communication
Letter of medical necessity
Nonverbal communication
Verbal communication

Introduction

Effective communication is a valuable adjunct to effective documentation. Because there are likely multiple consumers of your physical therapy documentation it is important to have a fundamental understanding of how to document various situations that may affect the care of your patient or client. Therefore, this chapter presents a clinical decision-making algorithm to assist you with determining which communications with a patient or client should become a part of the patient or client's health record. In addition, suggested ways of documenting verbal or electronic communications that may occur between you and your patient or client or those that occur between you and another individual on your patient or client's behalf are presented. Lastly, details regarding documenting requests to or from other healthcare providers on your patient or client's behalf, documenting refusals of service, or writing letters of medical necessity are also offered.

Communication is the cornerstone of a successful organization, whether that entity is a nonprofit group or a for-profit establishment. Without it, a business simply cannot operate. In addition to merely being present however, communication must also be detailed and timely to be effective. The medium via which communication occurs can vary as long as some mechanism exists to relay information. Equally important is a mechanism designed to receive that communicated information. In the healthcare sector, before the era of electronic health records, the contents of a health record became part of this legal document via transcription. For example, the contents of an entry were either handwritten or dictated, printed, and subsequently included in the record. The contents of a physical therapy daily visit was recorded on a prefabricated template utilizing a "SOAP" note acronym or was simply a blank page for the therapist to

create the note. Likewise, when a healthcare provider spoke to a patient or client or a colleague by phone, the details of the conversation were logged and became part of the patient or client's health record. The purpose of these types of entries was to maintain a record of all communications that occurred on behalf of the patient or client so that future questions or inquiries could be managed. It is important to recognize that communications with patients or clients, caregivers, and other members of the healthcare team continue to occur despite evolutions in technology. It is not the interactions that have changed; it is the means with which they are recorded. Although technology has evolved and these processes have largely become electronic, the core goal of communication has remained the same: to facilitate the exchange of information.

Clinical Decision Making in Communication

As a healthcare provider, communication is an integral part of patient- or client-centered care. As a physical therapy professional, you have a unique responsibility to be an effective and efficient communicator simply because of the increased amount of time you spend with each patient or client compared to other members of a patient or client's healthcare team. Furthermore, you have an additional responsibility to implement a decision-making process to determine which communications between you and your patient or client make it into the legal document that is the health record. Consider the following scenario.

> During her session today, your 15-year-old patient or client demonstrated and verbalized that she understood the details of the home exercise program that she is to perform over the next 3 days before coming back to your outpatient clinic for her next visit. The next day you receive a message from your front office administrator to call the patient or client as she has some questions about her exercises and would like to ask you about a pain that she has developed since her last session. You call her and have a brief conversation where you discover that she appropriately performed her exercises and is experiencing delayed onset muscle soreness. You educate her about this phenomenon and provide some detail about how she should dose her home exercises over the next 2 days.

Is it necessary to document the contents of this phone call? Take a moment to reflect on your answer. Consider an alternative situation where you discern, based on the contents of the phone conversation, that your patient or client injured herself when *inappropriately* performing the home exercise program you prescribed. Is this situation different from the previous scenario? Do you think that both scenarios warrant inclusion into the patient or client's health record?

Regardless of how communication occurs between you and your patient or client, it is your responsibility to capture in the health record any information that could potentially impact the physical therapy plan of care created with your patient or client. You could consider the plan of care to be a sort of contract, and therefore *any* communication that occurs that could affect the implementation and outcome of that contract should be recorded. Examples of this type of content include inquiries from the patient or client, caregiver, or healthcare provider about any aspect of the plan of care. Perhaps your patient or client's parent or sports coach inquires about the activities your 15-year-old patient or client should be doing with the sports team at school. Perhaps your patient or client's referring physician, nurse, or case manager calls to ask about the content of a re-examination you recently conducted. **FIGURE 9-1** depicts an algorithm you can utilize to assist your decision making regarding communications you may have on behalf of your patient or client.

APPROPRIATE COMMUNICATION

Because of your patient or client's right to privacy, the *appropriateness* of the communication is a proper initial factor to consider when determining the need to document communication in the health record. Consider that it is pertinent to first know if you are permitted to communicate with certain individuals on your patient or client's behalf before determining the need to capture the communication in the patient or client's health record. First ask yourself, "Is this communication appropriate?" To answer "yes" to this question, you must first identify with whom you have permission to communicate on your patient or client's behalf. If you

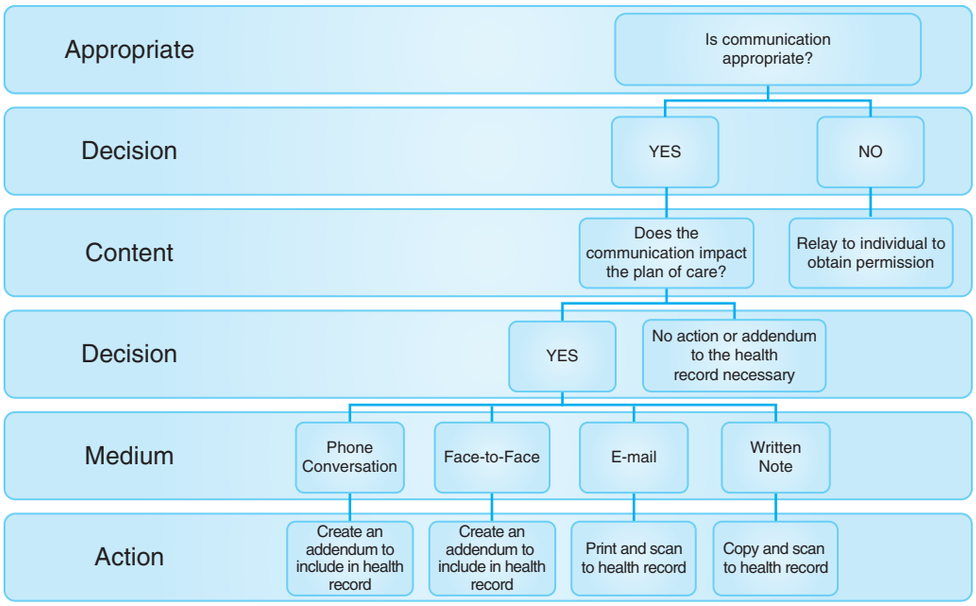

FIGURE 9-1 Communication Algorithm.

are engaged in communication with the patient or client in a clinical setting than you likely have his or her consent to do so. However, if you are approached by any other individual regarding the care of your patient or client, you must determine if your patient or client has consented to your communicating with that individual on their behalf prior to engaging in the conversation. This is an important part of your patient or client's right to privacy under the Health Insurance Portability and Accountability Act of 1996. Generally, your patient or client will have signed a form consenting to receive intervention from the healthcare providers employed at your facility. There will likely be a statement on this consent that includes the exchange of the patient or client's health information with providers outside your facility on their behalf. Your patient or client will also sign a disclosure indicating those individuals with whom you can communicate regarding their care. It is your responsibility to know who these individuals are, not only as a professional courtesy, but also because failure to do so is a violation of the law. Consider the following scenario.

> You are a physical therapist or physical therapist assistant in a busy outpatient clinic. You go to the waiting room to greet your patient or client and to walk into the clinic with her hoping to analyze her gait without her realizing it. As you walk behind your patient or client into the clinic gym, your patient or client's husband taps you on the shoulder and indicates that you should call his cell phone later that day. He states briefly that he has left his number with your front office administrator and that he wants to relay some concerns he has about his wife.

As the algorithm in Figure 9-1 suggests, you should first determine if it is appropriate for you to contact your patient or client's husband and begin communicating with him on her behalf. To do this you would have to refer to your patient or client's intake paperwork to determine if her husband is included on her disclosure as someone with whom you can communicate regarding her care. If you find that he is not listed, then you are not permitted to communicate with him on her behalf. In this case, you would indicate to your patient or client's husband that he would need to obtain permission from his wife before you could communicate with him regarding her health care. Because there was no information exchanged that could impact the plan of care or your patient or client's right to privacy, there is no need to include this communication within the patient or client's health record. Alternatively, if you feel concern that your communication with an individual regarding your patient or client may have the potential to impact the plan of care at some point, then it is

relevant to include the communication within your patient or client's health record. For example, consider that the request from your patient or client's husband is a repeated request that you have explained on multiple occasions. You might decide to include in your documentation the details of the husband's attempts to communicate with you regarding your patient or client and why you are restricted from doing so.

COMMUNICATION CONTENT

Once you have determined that communication is appropriate, it is suitable to determine the *content* of the communication. Ask yourself, "Does this communication impact, alter, or affect the plan of care in any way?" If the answer is "no," then further action or addendum to the health record is not necessary. To answer "yes" to this question you must possess an understanding of what details constitute meaningful communication that potentially impacts your patient or client's plan of care. It is straightforward to identify as communication any activity that identifies the care or service you provide during an encounter with a patient or client. These items, which include details of the elements of patient or client management as defined in the American Physical Therapy Association (APTA) *Guide to Physical Therapist Practice*, should clearly be included in the patient or client's health record (**TABLE 9-1**).[1] These details include the contents of the initial examination, evaluation and plan of care, as well as any outcome measures collected and interventions prescribed including the home exercise program. Daily notes, progress notes, re-examination notes, and conclusion of episode of care summaries are also clearly relevant content for the health record. Additional information such as medication lists, physician referrals, payer information, and content from any prior healthcare provider should also be included. It is not as straightforward, however, to identify as communication those activities that are appropriate to include in the health record that occur *outside* the context of a scheduled encounter with that patient or client (**TABLE 9-2**). Consider the following scenario.

> You are working in a skilled nursing facility where you are working with an older adult who is recovering from spine surgery. When you walk by his room you see that he is leaning over his bed to smooth out the blankets. You see that he is not wearing his thoracolumbosacral orthosis (TLSO). You enter the room and assist him with making the bed as well as donning the TLSO. You speak with the nursing team regarding your interaction with the patient or client.

Do you think that you should document this encounter in this patient or client's health record? If so, how did you decide? What information will you include in the record? Because the communication with the nursing team has the potential to impact the patient or client's plan of care, the encounter with the patient or client should be documented in the health record including the

TABLE 9-1 Communications to Include in the Health Record Based on the Elements of Patient/Client Management*

Initial examination, evaluation, and plan of care
Outcome measures
Daily notes
Progress or reassessment notes
Conclusion of episode of care summaries
Exercise flow sheets; intervention logs; postsurgical protocols
Home exercise programs
Physician referrals
Patient/client history and demographic information, medication lists
Informed consent
Payer information
Billing and coding information
Case management activities

* As defined by the American Physical Therapy Association.

TABLE 9-2 Communications to Include in a Health Record that May Not Be Part of a patient or client Encounter

Phone calls with the patient or client, caregiver, and/or other healthcare professionals
E-mail communications with the patient or client, caregiver, and/or other healthcare professionals
Face-to-face conversations with a patient or client, caregiver, and/or other healthcare professionals
Observations made of a patient or client that could impact the plan of care
Requests to healthcare providers for: ○ Operative reports ○ Imaging results ○ Referrals
Cancellations
Refusals of service
Conflicts with other appointments
Letters of support of letters of medical necessity

conversation that occurred with the nursing staff such as is indicated in the narrative below.

> Addendum to Daily Note for Mr. X on *insert date here:* At approximately 3pm, Mr. X was seen leaning over his bed. He was not wearing his TLSO. I entered his room, helped him don the TLSO, and made his bed for him. He stated that he was not having any pain and was hot, which is why he took off the TLSO. He stated that he had taken it off about 1 hour after his lunch was over at 1:00pm. He indicated that he often takes the TLSO off in the afternoon after lunch when he is resting in his room. I educated the patient or client on the importance of wearing his TLSO at all times including during sleep except when showering. I reiterated that he will need to wait for assistance from his nurse or occupational therapist for showering and bathing activities. I also educated Mr. X on how to change the thermostat in his room. Mr. X indicated that he understood the need for the continued use of the TLSO until he follows up with his surgeon in 2 weeks. I spoke with Mr. X's nurse immediately after speaking to Mr. X to relay the details above. The nurse indicated that she will check in on Mr. X more often and also reinforce the importance of wearing the TLSO to him as well as to her nursing staff.

This addendum relays the facts of what you witnessed and is devoid of any opinion. In addition, the actions you took on the patient or client's behalf including assisting him with the task he was attempting, educating him regarding his attempt to engage in this task without wearing his TLSO, and alerting his nurse are included. In addition to including your interaction in your patient or client's health record, it is important that you follow up in person with his care team, especially his nurse, to assure that the nurse is aware of an event involving a patient or client for whom she is responsible. Taking the time to create such an addendum in your documentation could further indicate, for example, details that assist other healthcare providers or the patient or client's family members to understand if the patient or client's recovery is not progressing as expected. Therefore, leaving this communication out of the health record has the potential to negatively impact the patient or client's plan of care.

Now consider that you are working in a busy outpatient clinic. You run out to your car to get your sweater and you see your patient or client who has had recent back surgery leaning into the trunk of his car to get his TLSO. It is your understanding that the patient or client is to wear this brace for at least 6 weeks. As you start your session, you see that the patient or client is wearing the TLSO. He indicates to you during your conversation that his surgeon told him that he does not have to wear the TLSO to drive.

Do you think that you should document this communication in this patient or client's health record? If so, how did you decide? Because this patient or client's behavior has the potential to impact his plan of care, it is relevant to include your observation and conversation in the health record. Equally important is your decision to follow up with the surgeon to verify any instructions regarding the TLSO and to subsequently include this conversation in the health record as well. Your daily note might look like the note below.

> Mr. Y reports a 7/10 pain across his central low back that started while he was getting dressed this morning. He states that he does not recall any specific action or position that increased his pain. He notes that he felt minimal pain (1/10) after his physical therapy session 2 days ago, which continued until this morning.
>
> Provided education to Mr. Y regarding the importance of wearing TLSO at all times except when showering including when driving and performing other activities. Mr. Y was observed retrieving his TLSO from the trunk of his car after exiting the driver's side of his car without wearing it. When questioned about the wear schedule for the TLSO, Mr. Y relayed that his surgeon told him he did not have to wear the TLSO while driving. Subsequently, Mr. Y was advised to wear the TLSO while driving or to make alternative arrangements for transportation until an alternative TLSO wear schedule could be confirmed with his surgeon. Positioning for dressing tasks was also reviewed and revised per flow sheet. Bending and stooping mechanics while wearing the TLSO were also included per flow sheet.
>
> Mr. Y demonstrated the ability to don his TLSO independently as well as perform bending and stooping to retrieve at least a 5-pound object from the floor without increased pain and without postural compensations while wearing his TLSO. He also indicated that he will attempt to wear his TLSO today while driving home but reports that this will be difficult because he

does not feel that he can safely drive while wearing it. He also states that he will speak with his wife about driving him to his medical appointments if he is to continue to wear the TLSO to drive.

Will place a call to Mr. Y's surgeon today to clarify TLSO wear schedule. Continue to address poor motor control at lumbar extensors to increase standing tolerance for grooming tasks and meal preparation.

A further addendum to this patient or client's health record can be included to reflect your communication with the patient or client's surgeon.

Addendum to Daily Note for Mr. Y on *insert date here*:

Spoke with surgeon's nurse, *insert name here*, via phone this afternoon who relayed that Mr. Y is to wear his TLSO at all times except when showering or bathing for the next 5 weeks until his follow-up appointment with the surgeon on *insert date here* at *insert time here* pm. The nurse indicated that he would contact Mr. Y today to reiterate this wear schedule. I also spoke with Mr. Y via phone after speaking with *insert name here* to reiterate the TLSO wear schedule. Mr. Y indicated that he understood and thanked me for calling.

As noted above, it can be challenging to identify the information your patient or client shares or exhibits in communications and interactions that occur outside the context of a scheduled encounter that should be included in the health record. Equally challenging is determining the content of communication exchanged with your patient or client that may not need to be included in the health record. This type of information can occur within the context of a scheduled encounter with a patient or client or outside the context of a scheduled encounter. Consider the following scenario.

During the physical therapy session, your postsurgical patient or client from the outpatient scenario above further discusses with you details about his friend who had a similar back surgery and who subsequently was prescribed a TLSO to wear for 6 weeks after the surgery. Your patient or client indicates that his friend only wore the brace for 3 weeks and fully recovered and returned to his job without wearing the TLSO for the prescribed 6 weeks.

Do you think that this detail should be included in this patient or client's health record? One could argue that your patient or client may make decisions about his own care based on the information he shared with you about his friend and with this rationale you might decide to include this detail in the health record. However, the content that is likely more appropriate for your patient or client's record is the education you provide about your patient or client's particular situation and wearing his TLSO as indicated.

Now consider that you encounter this same patient or client as you are waiting in line at the post office. He indicates that he was exhausted after his last physical therapy session. You chat about the weather, the traffic, and his work schedule where he indicates that his hours at work have increased again this week.

Do you think that you should document this communication in this patient or client's health record? If so, how did you decide? You may decide that based on your plan of care, your patient or client's mention of increased work hours is relevant to your plan of care. However, you may decide simply to make a point to ask him about his increased work hours and how it is affecting him and his current condition at his next session with you rather than document the conversation you had with him at the post office.

COMMUNICATION MEDIUM

Once you have determined that the content of your communication is relevant to include in the patient or client's health record, it is important to recognize that the mode of communication or the medium through which communication occurs (Figure 9-1) can also influence how the communication is recorded. Forms of communication that may affect the plan of care you have established with your patient or client include verbal, nonverbal, and written forms of communication. **Verbal communication** via a phone conversation or a face-to-face conversation can occur outside the context of the patient or client's actual visit but have an impact on the plan of care. In this case, the content of the verbal communication should be included in the patient or client's health record. **Nonverbal communication** can be expressed with gestures and other facial or body movements and may become important to you when the nonverbal message relayed is different than the verbal communications you may have had with your patient or client. Consider the following scenario.

You are working with an 85-year-old patient or client in a skilled nursing facility who is recovering from a stroke he suffered during cardiac surgery. He is surrounded by his loved ones and appears to have a large supportive family network. He appears motivated and positive when his family is present; however, you notice that his demeanor and energy level deteriorate when he is not with his family.

Do you think that this nonverbal behavior impacts your plan of care with your patient or client? Will you document the presence of this behavior? Why or why not? Because this nonverbal behavior has the potential to impact the plan of care you have established with this patient or client, you may decide that it is relevant to include it in your documentation, which may look like the following in your patient or client's daily note.

Mr. Z indicates that he practiced walking outside with his rollator that his family brought in today during his occupational therapy session.

See flow sheet for gait reassessment including TUG and 10MWT with and without the rollator. Vital signs show normal response at rest and with activity per flow sheet. Mr. Z appears lethargic and uninterested when using rollator for gait. Gait scores were significantly slower with use of the rollator than without per flow sheet; however patient or client demonstrated safety while maneuvering the rollator around turns and obstacles and over changes in floor surfaces.

Reassess gait during tomorrow morning's session to determine impact of fatigue on gait with rollator vs. no device. Monitor observed lethargy and low energy level.

Alternatively, Mr. Z's nonverbal behavior may trigger you to have a verbal conversation with the patient or client to determine the change in behavior that you observed, the results of which are indeed relevant to include in the health record. An alternative addition to Mr. Z's health record might appear as follows.

Addendum to Daily Note for Mr. Z on *insert date here*:

Mr. Z was observed today to be motivated and positive regarding his progress with physical therapy in the presence of his family this morning; however when his family left for the day, Mr. Z appeared unmotivated, lethargic, and uninterested in participating in any further activities. When asked about his change in demeanor, he relayed that his family does not want him to come home unless he uses the rollator that they brought in for him today. I discussed with Mr. Z that we would further evaluate his gait and balance and based on his progress would determine recommendations to share with his family regarding safety with ambulation and balance upon returning home. Mr. Z was agreeable to this plan and stated that his family was due to visit again in 2 days.

Written communication is most likely to occur in the form of an e-mail (a form of **electronic communication**), but can also come to you from the patient or client in a handwritten format. Assume that your 15-year-old patient or client from the scenario above sends you an e-mail communication rather than a phone call regarding her concern with her home exercise program and the pain she developed as a result. If you decide to reply to your patient or client via e-mail, should that reply be included along with the original e-mail from your patient or client as a permanent part of the health record?

Assume that you did not include in the health record your e-mail reply regarding your patient or client's inquiry. At her next appointment, your patient or client continues to complain of pain after doing the home exercises you prescribed. You ask her to perform the program so that you can ensure that she is utilizing proper form as well as to identify if she has made the appropriate adjustments that you relayed to her in your e-mail response. As you observe her form, you see that she has not incorporated the information you shared via your e-mail communication. Because she has incorrectly done this activity she has developed a persistent pain that is more than delayed onset muscle soreness. Leaving the e-mail communication out of the patient or client's health record omits an important part of the educational intervention that you delivered to your patient or client even though the educational intervention occurred outside the context of a scheduled encounter. In other words, you have not included an important part of the plan of care into the health record.

Revisit the scenario above, where your patient or client's husband asks you to call him to discuss his wife, your patient or client. Professionally, it would be appropriate to document the conversation as it is taking place. If you are not able to do this directly into the health record, it would be appropriate to take notes during the conversation so

that you can accurately create an addendum to the patient or client's health record as soon as you are able to ensure the accuracy of the information you include in the record. A similar approach to recording handwritten or verbal communication can occur during communication with a healthcare provider on your patient or client's behalf. Consider the following scenario.

> You have been working in the home of a patient or client who has Parkinson's disease. She is experiencing a decline in her executive functioning that is affecting her ability to prepare meals and organize her medications. She is going to visit her neurologist the following day. You decide with her permission to write down a few important points that should be brought up to the neurologist. She agrees to take this note to her physician for review during the visit. Later that day, the neurologist calls you to further discuss the patient or client's medical management as well as the care this patient or client is receiving in physical therapy.

Ideally, as indicated above, the documentation of the phone call with the physician should occur in real time in the patient or client's health record. However, circumstances may affirm that this is not feasible. Therefore, you should take notes so that you can either scan these notes as a permanent part of the health record or so that you can create an addendum to the health record based on the notes you took during the actual phone conversation. The addendum to your patient or client's health record may appear as below.

> Received a phone call from Dr. A, Mrs. B's neurologist this afternoon. She indicated that she saw Mrs. B for an office visit and thanked me for helping the patient or client with her list of concerns. The neurologist indicated that the patient or client will start on an alternative dosing schedule for her anti-Parkinson's medications tonight which should address the patient or client's complaint of fatigue and poor mobility upon waking in the morning. I will follow up with the neurologist per her request in 2 weeks to relay Mrs. B's mobility abilities in the morning hours to determine the effectiveness of new medication dose.

Additionally, a copy or recreated list of the details you asked the patient or client to share with the neurologist at her visit should also be included in the health record. Reflect for a moment on the value of including this information in the health record. Why would this detail be valuable to you and the neurologist or other members of the patient or client's healthcare team?

Regardless of the setting in which you practice, you will likely encounter a situation where you would like to initiate communication with another healthcare provider on behalf of your patient or client for information such as operative reports, imaging results, and referrals. Consider the following scenario.

> You are working with a patient or client after a rotator cuff repair. She suffered a major tear when she fell in her bathroom. She is progressing well and you are now interested in continuing her plan of care so that you can perform a fall risk assessment and subsequent fall prevention interventions based on her history. You call her physician's office to request a referral for a fall risk assessment and intervention. You leave a message with a nurse regarding this request.

Do you think it is important that you document this phone conversation in the patient or client's health record? Why or why not? Because obtaining this referral helps to determine how your plan of care will develop over time and how the patient or client's health insurance is utilized, it is important to include that you initiated communication to obtain this referral in the patient or client's health record. Alternatively, you may decide that it is beneficial to request information such as referrals or requests for supporting documents on behalf of your patient or client via written communication instead of a verbal or electronic request. Consider the following written communication to request a referral for additional physical therapy services on behalf of the patient or client in the above scenario.

> Date:
>
> Dear Dr. _____,
>
> I am the physical therapist who has been working with your patient or client, *insert patient or client's name here*, for a right rotator cuff repair after she suffered a tear due to a fall in her bathroom on *insert date here*. I have treated Mrs. A three times per week for 3 weeks. She is progressing towards her goals as outlined in her initial examination (attached). Her pain and function have improved to the point that we are able to address her fall risk and initiate fall prevention intervention. Please

sign and return the attached referral for fall assessment and intervention. Thank you.

Sincerely,

Insert your name and credentials here

A letter such as this may be necessary in the event that you did not include a desired assessment or intervention in your initial plan of care. This request could, alternatively, be imbedded in a re-examination note that you created during a reassessment of your patient or client. In this case, you would report on your patient or client's progress to date as well as report on newly collected outcome measures that identify your patient or client as being at risk for falls and create an appropriate plan of care to reflect this new information. Your electronic documentation system may allow you to create a status update or a report addendum to an initial examination or re-examination note in which objective data can be incorporated into a report that can then be faxed, e-mailed, or printed and given directly to the patient or client for delivery to the intended recipient.

Another communication that would warrant inclusion into your patient or client's health record is a cancellation or refusal of physical therapy services. Consider that you are working in an outpatient clinic and are expecting a patient or client for whom you are performing a re-examination today to determine his ability to actively move his ankle and ambulate since he no longer is required to wear a walking boot. Below is the addendum that you include in this patient or client's health record.

Mr. A cancelled his appointment today via message he left with front office due to his report of feeling nauseous. I called the patient or client to verify his next appointment tomorrow, *insert date here* at *insert time here*. I also indicated that today was to be the visit where I would have assessed his ability to move his ankle and ambulate without his walking boot and advised him to continue wearing the boot until our re-examination tomorrow.

It is likely that there is a location in a paper-based health record or a mechanism in an electronic record for recording cancellations and no-shows. It is also likely that this communication is entered into the patient or client's health record by the individual who received the message. However, due to the details that were to happen at the cancelled appointment, it is pertinent to ensure the patient or client's safety by following up with the patient or client and recording this additional communication in the patient or client's record. In addition, it is important to accurately document somewhere in the patient or client's health record that he or she cancelled or did not come to the scheduled appointment since policies regarding the termination of physical therapy services are based on this information.

If you practice in a setting such as an inpatient rehabilitation facility or a skilled nursing facility it is possible that you will experience a situation where your patient or client either refuses your services or has a scheduling conflict with another appointment. Consider that you enter your patient or client's room for his 8:30am physical therapy session. He indicates that he is exhausted because he did not sleep well the night before. Despite your efforts, your patient or client is not willing to participate in your session. You indicate to your patient or client that you will try back again right after his lunch at 1:00pm for a 30-minute session. Your documentation of your patient or client's refusal may look as follows.

Mr. A refused his morning and afternoon physical therapy sessions due to report of being exhausted and not being able to sleep last night. I initiated a conversation with his nurse regarding Mr. A's report and she indicated that if his vital signs are stable this evening that she will indicate to her staff to allow restorative sleep and not wake him between the hours of midnight and 6am.

Including this detail in the patient or client's health record will assist you as well as other members of the patient or client's healthcare team to understand and address any barriers that may exist to the patient or client meeting his recovery potential.

Creating Letters of Support or Medical Necessity

As a physical therapist, you may be asked to write a letter of support or medical necessity on a patient or client's behalf. This communication may be requested to support your patient or client's return to work, school, or sports activity; to recommend the suspension or termination of

certain job, school, or work-related activities; or to relay the need for disability license plates or paratransit services. Written communication may also be necessary to substantiate the need for durable medical equipment such as an ankle foot orthosis, a bedside commode, or a wheelchair. Requests for such written communication may come from a variety of sources such as another healthcare professional, an insurance provider, a durable medical equipment vendor, the patient or client's employer or school, or directly from the patient or client. Because the document you create will likely be used to make important decisions on your patient or client's behalf, it is important that all of the relevant information needed to make an informed decision be included in your communication. In addition, your letter should be written in such a way that it is appropriate for multiple audiences. Those making decisions on your patient or client's behalf may or may not be physical therapists or even healthcare providers; therefore, you should include enough detail about your patient or client's physical abilities that allows you to succinctly generate your clinical opinion and relay your recommendations. Consider the following communication on behalf of your patient or client to support that she is unable to perform her current work duties.

Date:

United States Department of Labor

Office of Workers' Compensation Programs

P.O. Box 1234

Washington , DC 20210

To Whom It May Concern:

I am a physical therapist writing in response to a request from Ms. B to write a letter on her behalf regarding her physical status. I treated Ms. B at *insert your clinic name here* for a total of seven visits from *insert date here* to *insert date here* for neck pain. Her physical therapy examination (attached) is consistent with a repetitive strain injury at her cervical spine with concurrent headaches that appear to be cervicogenic (coming from the cervical spine) in nature. Ms. B describes her job duties to include heavy lifting, repeated reaching and sorting, and repeated use of her arms overhead in a mailroom. She reports that she currently works 8-hour shifts 4–5 days per week and that she has been taking personal leave to attend physical therapy sessions. Ms. B makes intermittent and limited progress with physical therapy intervention. Any gains achieved are negated after 2–3 days of performing her current work duties.

At this time I recommend that Ms. B avoid lifting parcels and boxes > 10 pounds and to avoid any overhead lifting or sorting. She would likely benefit from a postural change such as sitting every 30–45 minutes and the use of a step stool so that she can be eye level with the areas she is required to reach. These modifications will likely assist her so that she can continue to be productive on her shift.

Please contact me at with any further questions.

Sincerely,

Your name and credentials here

The above letter opens with brief and important detail regarding the purpose of the letter followed by your interpretation of the problem as well as your recommendations. It is also pertinent to invite the recipient to contact you should any further questions develop.

Additional guidelines for the content that is relevant to include in a **letter of medical necessity** is relayed in **TABLE 9-3**. Your success in your ability to communicate via a letter of medical necessity will lie in your ability to briefly translate your clinical findings such that a

TABLE 9-3 Content of a Letter of Medical Necessity

Brief statement of the purpose of the communication
Brief narrative of relevant history and current condition ○ Health condition ○ Activity limitations and participation restrictions ○ Contextual factors that affect function
Results of relevant objective tests and outcome measures performed
Interpretation of relevant objective tests and outcome measures performed
Summary of findings that interfere with function and that necessitate need for assistance ○ Statement of why certain activity limitations and participation restrictions are listed ○ Statement as to why alternative equipment or services are inferior ○ Statement as to why the recommended equipment or service will assist with current limitations and restrictions
Recommendations based on presented data and clinical judgment
Contact information for further inquiries

nonclinical professional can recognize and concur with your recommendations. Furthermore, a succinct and informative opening sentence will improve the likelihood that the remainder of the letter will be read. Consider the following letter of medical necessity for a power wheelchair.

Date:

To Whom It May Concern:

Insert name here is a 52-year-old man who was referred to *insert your name or clinic name here* for a wheelchair assessment performed on *insert date here*. Mr. C was diagnosed with MSA 2 years ago. He is limited in all ADLs. He relies on his wife for assistance with bed mobility and transfers. He is extremely bradykinetic and rigid throughout his body. He experiences resting tremor in both UEs and LEs that is more prominent and physically limiting when fatigued. He experiences pain in his neck, back, hips, legs, and feet. Mr. C is able to ambulate short distances with a cane. He experiences freezing episodes and requires assistance to stop his festinating gait pattern and loss of balance. It takes Mr. C several minutes to ambulate as little as 50 feet. Mr. C has a history of frequent falls. As a result Mr. C is interested in obtaining a power wheelchair to assist him in performing ADLs with less pain, and increased safety and independence. Please see the objective data from Mr. C's physical assessment below.

Observation/Posture: Forward head, protracted c-spine, rounded shoulders, increased t-spine kyphosis; decreased lumbar lordosis.

Pain: Constant 8/10 pain throughout neck, back, hips, legs, and feet B.

Sitting Balance: Limited by pain and poor postural strength.

Standing Balance: Min to mod A needed to stand from sitting depending on the height of the sitting surface.

Transfers/Bed Mobility: Mod to max A due to muscular rigidity and pain.

Gait: With straight cane for very short distances (910 feet) with mod to min A × 1, requires sitting rests due to fatigue; toe-heel pattern noted.

UE AROM/PROM: Limited AROM of B shoulder flexion, abduction, and extension; all limited by pain.

UE Strength: UE strength is grossly 3+/5 to 4–/5 B; limited by pain.

LE AROM/PROM: AROM of B LEs limited by pain. B passive hip extension = 5 degrees; B knee extension = –10 degrees indicating knee flexion contractures. Ankle DF = 10 degrees R; 5 degrees L.

LE Strength	Right	Left
Hip flexion	3+/5	3+/5
Hip extension	4–/5	4–/5
Hip abduction	3+/5	4–/5
Hip int rotation	4/5	4/5
Hip ext rotation	3+/5	4–/5
Knee flexion	4–/5	4–/5
Knee extension	3+/5	3+/5
Ankle dorsiflexion	4/5	4/5
Ankle plantarflexion		Unable to raise up on toes

Tone: Increased in B UEs, LEs, and trunk.

Coordination/Fine Motor Control: Undershooting targets observed.

Based on the findings outlined above, I recommend a power wheelchair to meet Mr. C's needs.

Sincerely,

Insert your name and contact information here

Is the detail provided here valuable enough to warrant that this patient or client receive a power wheelchair? Why or why not? Is there any additional information you would you use to determine if this patient or client would benefit from a power wheelchair? What components as indicated in Table 9-3 are missing from this letter?

Table 9-3 indicates that a brief statement of the purpose of the letter should be included. The above letter indicates that a wheelchair assessment was performed at the encounter. However, a separate opening sentence that briefly connects the reader to you as the communicator is warranted. By adding this sentence, the patient or client's healthcare provider or insurance carrier can immediately identify that the letter requires their attention. Mr. C's history and current condition in the narrative that follows are not provided in enough detail for the reader to understand the activity limitations, participation restrictions, and contextual factors present that affect Mr. C's function. The letter does refer the reader to the objective data

from Mr. C's physical assessment; however, an interpretation of these findings is absent. This critical information will help the reader draw the link between the stated activity limitations and participation restrictions and the impairments in body functions and structures identified during the physical examination. In addition, many sentence fragments and abbreviations are used throughout the physical examination findings, which further limit the ability to synthesize the presented data. A narrative summary of the findings that interfere with Mr. C's function and that necessitate need for assistance is also absent from this letter of medical necessity. Detail regarding why equipment or services alternative to that which are recommended is also needed. If your audience is the entity who is paying for the needed equipment or service, an explanation as to why a lower-cost option is not appropriate for the patient or client will be sought. It is important to re-summarize why the recommended equipment or service will assist with the patient or client's current limitations and restrictions at the end of the letter so that the reader is not required to scour the letter for details of your assessment to find information relevant to the decision at hand. It is also important to invite the reader to contact you should any questions about your recommendations remain. This sentence will help relay that your letter was not a computer-generated form letter, but a communication specific to the needs of your mutual patient or client. Now consider the more detailed scenario below.

Date:

To Whom It May Concern:

I am a physical therapist writing today to support a request from your client, *insert name here*, for *insert reason for communication here*.

Insert name here is a 52-year-old man who was referred to *insert your name or clinic name here* for a wheelchair assessment performed on *insert date here*. Mr. C was diagnosed with multiple system atrophy, a Parkinson's disease-like progressive movement disorder 2 years ago. The complications of this disorder have limited Mr. C's ability to perform activities of daily living such as dressing, grooming, bathing, toileting, and ambulating. He relies on his wife for assistance with bed mobility and transfers as he is unable to independently perform these activities due to the symptoms of this disorder. He is severely bradykinetic during any physical movement and therefore the activities he performs are severely slowed. This slowed movement is inefficient and contributes to Mr. C's constant complaint of fatigue. Bradykinesia not only affects skeletal muscle but also smooth muscle. Mr. C, therefore, lacks a cough reflex and has slowed digestive motility. He is extremely rigid throughout his body, especially his neck and trunk, which contributes to his swallowing difficulties. He experiences resting tremor in both upper extremities and both lower extremities that is more prominent and physically limiting after his musculoskeletal system has been stressed as in during any movement or when he is fatigued. He experiences constant and deep aching pain in his neck, back, hips, legs, and feet due to muscular rigidity and neuropathy. Mr. C is only able to ambulate short distances, up to 50 feet, with a straight cane. However, he experiences freezing every two to three steps and requires the assistance of another person or object such as walls or furniture to stop his festinating gait pattern. It therefore takes 3–4 minutes to ambulate 50 feet. As mentioned, his tremor, rigidity, and bradykinesia increase as his effort level increases. Mr. A has a history of frequent falls and reports falling four times in the last week. All of these falls occurred during ambulation to the commode or when trying to ambulate in his home. As a result of these limitations and restrictions, Mr. C is interested in obtaining a power wheelchair to assist him in performing activities of daily living with increased safety and independence. Please see the objective data from Mr. C's physical assessment below.

Observation/Posture: Mr. C has a forward and protracted cervical spine, rounded shoulders, and an increased thoracic kyphosis. When sitting in a backed chair, Mr. C's posterior shoulders and upper thoracic spine do not contact the chair given his severe forward leaning posture. He lacks a significant lumbar lordosis and therefore sits in a slumped sacral sitting position. This posture forces Mr. C to extend his thoracic and lumbar spine in order to direct his gaze at someone sitting in front of him. Additionally, this posture suppresses Mr. C's cough reflex, swallowing mechanism, and ability to project his voice to be heard. This posture is not adequate for propelling a manual wheelchair as he loses his balance forward when attempting to contact the wheels for propulsion. He also lacks the flexibility to use his arms to advance the chair. See upper extremity range of motion findings below.

Bradykinesia and rigidity prevent him from propelling the chair with his legs and feet.

Pain: Mr. C complains of constant pain throughout his neck, back, hips, legs, and feet bilaterally. He is unable to move freely due to muscular rigidity and cramping. He also experiences burning neuropathic pain in both feet. He is able to find minimal relief of his back pain sitting in a reclined position. A power wheelchair is the only mobility device that has the adjustability in the seating system to tilt or recline allowing Mr. C the ability to locate a position that will minimize his pain and allow him the opportunity to complete daily activities such as grooming, dressing, and eating.

Sitting Balance: Mr. C's sitting balance is limited by pain and poor postural strength. He requires both upper extremities on the seat to impart support in sitting. His forward posture as previously mentioned is such that he slumps forward and looks down. He is unable to independently adjust his position to provide pressure relief due to bradykinesia and rigidity. He is able to sit without back support for less than 5 minutes before requiring the assistance of another person to move to a reclined position.

Standing Balance: Mr. C requires minimum to moderate assistance to stand from sitting depending on the height of the sitting surface due to muscular rigidity, pain, bradykinsesia, and difficulty planning volitional movements. A functional balance assessment was not possible due to the above mentioned impairments.

Transfers/Bed Mobility: Mr. C requires moderate to maximum assistance with bed mobility and transfer tasks due to muscular rigidity, pain, bradykinsesia, and difficulty planning volitional movements.

Gait: At the evaluation, Mr. C ambulated with a straight cane in his right hand 25 feet before needing a sitting rest due to the fatigue of developing a festinating gait pattern and freezing every two to three steps. He utilized a toe-heel pattern often catching his toe on the floor during the swing phase of gait. He consistently required the assistance of another person to stop his momentum to prevent a fall. He is unable to use a standard or a rolling walker as it increases his tendency to freeze by becoming an obstacle in his path. He is unable to coordinate the movement patterns necessary to advance one foot in front of the other while also advancing the walker.

UE AROM/PROM: Mr. C has limited active range of motion (ROM) of bilateral shoulder flexion, abduction, and extension to approximately 140 degrees, 150 degrees, and 40 degrees, respectively. All ROM measures are limited by pain. As previously noted, he has a severely forward posture such that the posterior shoulders and upper back do not contact the back of the seat in which he is sitting. These limitations would prevent Mr. C from propelling an optimally configured manual wheelchair.

UE Strength: Upper extremity strength is grossly 3+/5 to 4–/5 bilaterally. All planes are limited by pain.

LE AROM/PROM: Active ROM of bilateral lower extremities is limited by pain. Passive hip extension is limited to approximately 5 degrees bilaterally. Bilateral knee extension is limited to –10 degrees indicating knee flexion contractures. Ankle dorsiflexion is 10 degrees on the right and 5 degrees on the left.

LE Strength: Lower extremity strength is grossly 3+/5 to 4–/5 bilaterally. All planes at the knee and hip are limited by pain.

Tone: There is increased resistance to passive movement of Mr. C's bilateral upper and lower extremities and trunk, especially, hip flexion, internal rotation, external rotation, knee flexion, and hip adduction. Trunk rigidity is apparent when Mr. C attempts to initiate a movement such as leaning forward to get out of a chair or when initiating rolling which compromises his balance and therefore his ability to complete daily activities.

Coordination/Fine Motor Control: Mr. C has upper extremity motor control deficits, as he tends to undershoot targets and misjudge distances. He is unable to coordinate the fine motor skills involved in brushing his teeth, and fastening buttons and zippers for dressing. He also requires assistance to eat as he has difficulty using utensils to cut food and bring food to his mouth. Mr. C also lacks lower extremity motor control apparent when attempting to place his foot near a target in sitting or standing. The deficits in motor coordination cited above would interfere with Mr. C's ability to propel and maneuver a manual wheelchair. He does however possess the physical and mental ability (Mini-Mental State Exam = 27) to operate a power wheelchair with a joystick device on his dominant side in the home, as trunk and extremity movement would be

minimized with the operation of this type of device. A power scooter is inappropriate for reasons previously mentioned such as Mr. C's need for a seating system that can provide a tilt or recline. A scooter is also insufficient for assisting Mr. C with pressure relief or postural repositioning as it does not possess the supportive system needed to accommodate Mr. C's postural rigidity and tone.

Based on the findings outlined above, I recommend a power wheelchair with a joystick, a seating system that allows for a tilted and reclined sitting position, and elevating leg rests. These features will allow Mr. C the ability to independently maneuver around his home so that he can gain control over activities of daily living such as grooming and dressing. As previously noted, abnormal tone, poor postural structure, limited range of motion, muscular weakness, and pain prevent Mr. C from independently maneuvering a manual wheelchair around his home. Parameters such as speed, acceleration, and joystick sensitivity can be programmed electronically to allow Mr. C the opportunity to freely move through the rooms of his home including his bedroom, bathroom, and kitchen. Additionally, the electronics for a tilt and recline system at the joystick will afford Mr. C the opportunity to independently manage his sitting posture for pressure relief and for basic needs such as swallowing and eating.

Thank you for your assistance in meeting Mr. C's needs. Please contact me at *insert information here*, if I can be of any further assistance.

Sincerely,

Insert your name and credentials here

Clearly, this letter is more detailed than the first. The opening statement briefly directs the reader to the purpose of the communication. The narrative format of the letter relays Mr. C's health condition as well as the factors that currently limit his ability to function. The narrative format of the physical assessment also relays important detail and connects Mr. C's limitations and participation restrictions with his impairments in body functions and structures. An interpretation of how these impairments will affect Mr. C is also included. Explanations supporting the recommended equipment and supporting why lower cost equipment would not benefit Mr. C is provided. A summary paragraph concludes the letter re-emphasizing the most relevant reasons why the recommendation is being made.

Summary

The ability to create and translate verbal and written communication clearly and succinctly will supplement your proficiency as a physical therapy professional. As

BOX 9-1 Electronic Health Record: Interprofessional Communications

Some electronic systems may have a mechanism for you to create an addendum to the patient or client's health record should the communication you wish to include occur outside the context of a scheduled encounter. You may have an opportunity within your system to copy and paste the details of communication such as an e-mail into this section. Alternatively, you could print the e-mail communication and scan it into the patient or client's record much like an external document such as a fax communication from a referring physician's office or a paper-based outcome measure that you collected at the initial examination. If communication comes to you in the form of a handwritten note, you could similarly scan this document to your electronic system for inclusion into the patient or client's health record.

There may be an opportunity within an electronic documentation system to create a report or template so that an outline of the desired information for a letter of medical necessity for a certain piece of equipment is provided to you as the examining therapist. This template could be used as a guide to follow during an examination to ensure that all relevant data is considered and collected so that the content of the letter of medical necessity is optimal. Even if you have the opportunity to collaborate with a professional whose primary function is to obtain the desired durable medical equipment, it is important to possess an understanding of the content of a letter of medical necessity in the event you are asked to create one.

technology evolves and electronic documentation systems are implemented, the need to consistently develop the framework for your communications may dissolve. However, you are still responsible as a physical therapy professional to recognize and understand how to effectively and efficiently document the content of professional communication. This includes:

- Distinguishing which communications with patients or clients and caregivers should be documented within a health record and which communications should not.
- Determining where in the health record communications should be recorded should they occur outside the context of a scheduled encounter with a patient or client.
- Recognizing how to document communications with other professionals on behalf of your patient or client.
- Creating the framework and content of letters of support and medical necessity on behalf of your patient or client.

The templates for creating the communications included in your documentation such as letters of medical necessity may be prefabricated. However, as a physical therapist you should be informed and aware of how to create these documents as if the protocol or template did not exist. In the event that an electronic system does not exist or fails, your patient or client may still call on you to communicate on his or her behalf. You will then be required to do so effectively and efficiently.

Discussion Questions

1. Choose an orthopedically focused examination you performed recently in the clinical setting in which you practice.
   a. Write a mock letter of medical necessity for a brace or splint.
   b. Exchange letters with one of your peers or colleagues. Assume that you are the party responsible for determining if this patient or client receives the brace or splint. Based on the letter you read, would you accept or deny the request? Provide specific support from the letter to support your decision.
2. Choose a neurologically focused examination you performed recently in the clinical setting in which you practice.
   a. Write a mock letter of medical necessity for a wheelchair.
   b. Exchange letters with one of your peers or collegues. Assume that you are the party responsible for determining if this patient or client receives the wheelchair. Based on the letter you read, would you accept or deny the request? Provide specific support from the letter to support your decision.
3. You evaluate a 30-year-old man 2 weeks after he experienced a whiplash injury in a car accident. He states that he has had an x-ray and an MRI but he does not know the results of these tests. Write a letter on your patient's behalf requesting this information.
4. Your 16-year-old baseball player is recovering from a labral repair on his pitching arm and is eager to participate in strength and conditioning practices. His coach contacts you and wants to know what activities are safe to perform in these practices. Create an addendum to your re-examination note to your patient or client's coach relaying your recommendations.
5. Your patient or client is a 42-year-old contractor who fell off a ladder while at work and injured his back. He has been participating in physical therapy with you three times per week for 12 weeks. He indicates that he needs a letter from you recommending a functional capacity examination before his employer will allow him to return to work. Create this letter on behalf of your patient or client.
6. You are working in an inpatient rehabilitation facility. You learn from your occupational therapy partner that your patient or client left in the middle of the OT session to have an EKG performed. Your patient or client has still not returned by the end of your day and as a result you missed 60 minutes of physical therapy intervention with him. How will you document this situation in your patient or client's health record?

Case Study Questions

1. You are treating your patient or client in a busy inpatient rehabilitation hospital when the patient or client's son approaches you and asks why he was not notified about his mother's admission to the emergency room the day before for a hypertensive episode. He further relays to you that his mother's sister, his aunt, was notified. He indicates that his aunt is not on his mother's disclosure and consent as

someone your company is authorized to discuss your patient or client's health information. You apologize for this oversight and assure your patient or client's son that you will relay this problem to the healthcare team to determine how this mistake was made. Based on this scenario, create the documentation you would include in the patient or client's health record of the conversation you had with her son.

2. You are working in a busy outpatient clinic and are awaiting the arrival of one of your patients or clients. She is late and you are concerned since she is never late. Just then, you see an ambulance outside of your facility in the parking lot and realize that your patient or client's caregiver is standing there as well. You go outside and learn from your patient or client and her caregiver that she fell in the parking lot. You see that she is scraped and cut on her head above her right eye, on her right shoulder, and on her right knee. She states that she is very painful at her shoulder, but is otherwise just embarrassed. She states that she will call you later with an update on her status.
   a. Should the communication you had with your patient or client and the caregiver be included in the patient or client's health record?
   b. If you decide to include this communication in the health record, what will you write?
   c. If you decide not to include this communication in the health record, indicate your reasoning for your decision.
3. You are shopping at the grocery store one afternoon and you run into one of your current patients or clients who you are treating in your outpatient clinic for shoulder pain. You notice that she is using her shoulder with many of the postural compensations that you spent her previous physical therapy session working to address. She mentions to you that she is still having pain and that she is not sure that physical therapy is helping her. You mention your observations about how you see her using her shoulder and offer some suggestions on how she might change her positioning to facilitate the use of her arm in a less painful way. She indicates an understanding of and an appreciation for what you have shown her and states that she will see you tomorrow at her next appointment.
   a. Should the communication you had with your patient or client and the caregiver be included in the patient or client's health record?
   b. If you decide to include this communication in the health record, what will you write?
   c. If you decide not to include this communication in the health record, indicate your reasoning for your decision.
   d. Your patient or client arrives for her appointment the day after you spoke with her about her body mechanics and postural positioning of her shoulder at the grocery store. She states that she is in more pain than she was when she saw you in the store yesterday. She indicates that it was the advice that she followed from your suggestions that increased her pain. After reassessing her movement and further educating her, she now understands what activities to avoid and how to position herself. How will you document this information in your daily note?
4. You are working in an acute hospital setting with a gentleman who suffered a hip fracture after a fall that was surgically fixated 4 days ago. The patient or client's surgeon stops you in the hall and indicates that he has removed any weight-bearing precautions that were initially in place. How should you incorporate this communication with the surgeon into the health record?
5. You are attending a case conference on behalf of a patient or client with whom you are working in his home. The case manager asks you about the content of a re-examination you performed 2 days ago. She indicates that you as the physical therapist are the only discipline that performed a re-examination to continue his care. The case manager reports that nursing and occupational therapy have concluded the episode of care for the patient or client. She questions if you still think that this patient or client requires home health physical therapy intervention and seems to be implying that she would like you to conclude the physical therapy episode of care for the patient or client. You present your findings again and substantially support why you are continuing physical therapy services with this patient or client.
   a. Should you document the conversation with the case manager in the patient or client's health record?
   b. If you decide to include this communication in the health record, what will you write?
   c. If you decide not to include this communication in the health record, indicate your reasoning for your decision.
6. You receive a phone call from a local football coach who is inquiring about the status of your patient or client who is also one of his star players. You determine from the patient or client's informed consent that you are not permitted to disclose health information to the coach about your patient or client.
   a. Should you document this conversation in the patient or client's health record?
   b. If you decide to include this communication in the health record, what will you write?
   c. If you decide not to include this communication in the health record, indicate your reasoning for your decision.

7. Consider the following letter of medical necessity.

Date:

To Whom It May Concern:

Insert name here is a 77-year-old female who was referred to *insert your name or clinic name here* for a power wheelchair assessment performed on *insert date here*. Ms. Z's medical history includes macular degeneration, osteoporosis, and osteoarthritis. She had a right total knee replacement 5 years ago and currently experiences limitations as a result of left knee osteoarthritis. Approximately 1 year ago, Ms. Z experienced a fall resulting in a left hip fracture. Since this time she has used a standard manual wheelchair. Ms. Z experiences pain, weak trunk musculature, a thoracic kyphosis, and poor shoulder extension ROM that severely limit her ability to propel the manual wheelchair. Please see below for the objective findings from Ms. Z's *physical* assessment.

Observation/Posture: Forward, protracted cervical spine, rounded shoulders, increased thoracic kyphosis. Lateral R trunk lean, elevated L iliac crest in sitting. Standing limited to 2 minutes. Tends to have loss of balance to R when standing regardless of UE support.

Pain: Constant throughout upper and lower back, L hip, knee.

Sitting Balance: Limited by poor postural strength.

Standing Balance: Ms. Z requires SBA to CGA during standing without UE support. Unable to stand safely for greater than 8 seconds with upper extremity support, or her cane, without also reaching out for assistance with her other hand. BBS = 25/56.

Transfers/Bed Mobility: Mod I for transfers, bed mobility.

Gait: Ambulates with a straight cane in R hand and her son at her L side. He provided Ms. Z with mod to max A for approximately 75 feet before she required a wheelchair due to the fatigue and pain. Ms. Z also relied on her son for direction during ambulation, as she is unable to see the details of a change in flooring such as tile to carpet or a doorway threshold due to macular degeneration.

UE AROM/PROM: UE AROM WFL except shoulder extension, which is limited B to approximately 45 degrees by her thoracic kyphosis.

UE Strength: Grossly 4/5 bilaterally.

LE AROM/PROM: L knee AROM limited by pain. R knee AROM WFL. L knee extension lacks 20 degrees. Passive hip extension is limited to approximately –10 degrees B.

LE Strength	Right	Left
Hip flexion	4/5	3+/5
Hip extension	4–/5	4–/5
Hip abduction	3–/5	3–/5
Hip adduction	2+/5	2/5
Hip internal rotation	3/5	3/5
Hip external rotation	4–/5	4–/5
Knee flexion	4–/5	4–/5
Knee extension	4/5	4–/5
Ankle dorsiflexion	4/5	4/5
Ankle plantarflexion		Unable to raise up on toes

Based on the findings outlined above, I recommend a standard power wheelchair to meet Ms. Z's needs.

Sincerely,

Insert your name and credentials here

Is the detail provided here valuable enough to warrant that this patient or client receive a power wheelchair? Why or why not?

How would you change the letter so that the detail provided is meaningful to an audience who may not be a physical therapist or even a healthcare provider?

References

1. American Physical Therapy Association (APTA). *Guide to Physical Therapist Practice*, 1st ed. Arlington, VA: American Physical Therapy Association; 2014.