

Procedures: Documentation

Date Written: 08/07

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Sumlar Therapy Services, Inc.

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Legibility: All documentation must be legible. If documentation cannot be easily read by another individual, it may not be considered a legal record of a therapy session. It is the employee's responsibility to provide legible documentation.

Co-signing for Therapist Assistants: Therapist assistants should always sign their name and credentials to their documentation, leaving room for their supervising therapist to co-sign. Assistants' notes should be co-signed by the supervising therapist.

Change of Status Forms: When a patient is discharged, ages out of EI, moves out of the current system, or dies, complete this form and turn it in or fax to the OA (Office Administrator) to keep your patient's status updated in the STS database. This form is used for ALL patients.

School Forms: For every student, use the following four forms:

1. **School Information Cover Sheet:** The treating therapist should complete this form the first time they see a child, as well as during the first week of a new school year. This form should be the last page (on the bottom of the stack) in every patient's section in your notebook. Fill it out completely so that if the patient is transferred to another therapist, or a therapist is filling in for you, the new therapist can proceed with ease.
2. **School Record:** This form will serve as your therapy visit record. Benchmarks should be entered in the appropriate section, either "pasted" from the evaluation or written in by hand, and the appropriate number of copies should be made early on. There are nine columns to the right of the benchmarks. Each column represents one treatment session. Write the date in the top of the column, and use the key (M, +, -, 0) to indicate which goals you addressed and the outcome. A short note should be written for each treatment session, below the benchmarks. Every note should be dated and signed. When you run out of columns or room for notes, begin a new sheet.

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- 3. Quarterly School Progress Report:** The treating therapist should enter benchmarks either by handwriting or “pasting” from the evaluation. There are two keys below the benchmark list, and both sets should be used to evaluate each goal, each quarter. Below the key is space for the therapist to write or type a short summary for the parent’s benefit. Information should be written in parent-friendly terms; stay away from medical jargon as much as possible. Keep the master copy in your notebook, send one copy home with the child, and give one copy to the IEP holder. Ask the teacher to enter the information about the goals into the SETS program if needed.
- 4. Therapy Note** (carbon copy, two-part form): This is a generic note that the therapist can use for purposes such as: communication with a parent about the day’s treatment session (on a regular basis or on an irregular basis); communication with a teacher or paraprofessional; or to inform or educate caregivers about carryover techniques, new equipment, or appointments. You do not have to write anything in the top box, and can just use the bottom box, or vice versa. There are three choices in the bottom box *ATTN: Parent/Caregiver/Teacher*—circle the person to whom you are addressing the note. If you would like the parent, caregiver, or teacher to call you, check the box at the bottom: *Requires Your Response* with the office number. Feel free to add your cell phone number if you prefer.

A fifth form shall be used in the schools if the therapist attends the IEP meeting:

IEP Meeting Outcome Form. Complete the form in full, and keep this form with your most recent evaluation when starting the new school year.

Early Intervention Forms: There are three forms and one card for EI use.

- 1. Early Intervention Information Cover Sheet:** The treating therapist should complete this form the first time they see a child. This form should be the last page (on the bottom of the stack) in every patient’s section in your notebook. Fill it out completely so that if the patient is transferred to another therapist, or a therapist is filling in for you, the new therapist can proceed with ease. Please provide directions to the patients’ home. Keep phone numbers and addresses updated and notify OA of changes.
- 2. Therapy Progress Note** (carbon copy, two-part form): This is the primary note for every therapy visit. Please circle the appropriate service (PT, OT, or ST) and note the EI program and place of service (home, daycare, etc.). In the box titled *IFSP outcomes* you should list the general goals you are working on in parent-friendly terms. In the box entitled *Summary of Session* please note subjective, objective, assessment, and plan information, using parent-friendly language, not medical jargon whenever possible. Also, don’t forget to include parent concerns. The third box is entitled *Parent/Cargiver: Please work on . . .* Here is the spot for

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you to list a few techniques, games, carryover items for the parents or caregivers to focus on until you return (parent education). Write some information in every box. Do not skip any one of the three areas, as each is designed to cover a specific area required by the Early Intervention reviewers. Sign, enter time in/out, date, and have the parent sign. Note the time, day, and date of the next appointment, or note that you will “call to schedule.” Leave the yellow copy with the parent/caregiver. Keep the original white copy in your notebook. At the end of the month, a copy of every EI note is due in the office so that it can be distributed with the monthly invoice. The treating therapist is responsible for copying the notes and turning them in.

3. **Early Intervention Record:** This form will serve as an adjunct to your Therapy Progress Note. Long-term and Short-term Goals should be entered in the appropriate section, either “pasted” from the evaluation or written in by hand, and the appropriate number of copies should be made early on if desired, to decrease the need for duplicating your work. There are 9 columns to the right of the benchmarks. Each column represents one treatment session. Write the date in the top of the column, and use the key (M, +, -, 0) to indicate which goals you addressed and the outcome. When you begin addressing new short-term goals, add them in the appropriate column and date your entry. (Assistant Therapists can write new short-term goals, as long as they do not surpass the Long-Term Goal established by the treating therapist.) When you run out of columns or room for notes, begin a new sheet, carrying over the current applicable goals. Document your parent contacts, absences, no-shows, schedule changes, etc. on the bottom of this form. Copy this form at the end of the month in addition to the visit notes and turn into the office.

4. **Missed Visit Card:** this ¼-page colorful card is to be left at the place of service when the therapist makes a visit and the child is not available. The therapist writes the date and time at the top of the card, and then marks one or both of the choices and signs the card. This can be left at a residence, tucked in the door, or left at a daycare. The spot for a name was purposefully left off the form to maintain privacy if left on the exterior of a residence. If left in a daycare, the therapist or daycare employee may write the name of the child on the card, and place in the child’s cubby for the parent. NOTE: Missed visits (No-Shows) should also be documented on the EI Record.
 - **Early Intervention Absences:** Please report every “No Show” to the IFSP holder via email or phone within two business days of the occurrence. The IFSP holders may choose to put further therapy on hold until the families can be contacted for explanation. Excessive No Shows or Cancellations by an EI family may also necessitate their discharge from the EI program, which is a decision made by the family and the case manager.

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Therapists are required to turn in **all EI Progress Notes and EI Records for the entire month**. Acceptable methods include scanning and emailing, faxing, or copying and filing in the designated area in the front office.

Clinic Forms: There are two types of clinic notes and an update form. As the treating therapist you may choose either progress note format.

1. **The three column progress note:** Write your short-term goals in the column on the left. At the bottom left is some space for additional notes: enter cancellations, no-shows, or parent contacts here or in one of the columns. You may enter up to three therapy sessions on one page.
2. **Or, the SOAP note:** Write your goals in the indicated portion, and then use the next two boxes for two soap notes. Use a box to record no-shows, cancellations, parent contacts, etc.
3. **Tricare Update Reports:** Tricare authorizes only a certain number of visits, and then requires an update. Our solution has been to create a special report via computer that can be completed by the therapists, which can then be entered into the Tricare system online by an Office Administrator. The OA will email you the report with significant dates already entered. Please complete the report on the computer, save, and email back to the OA. The therapist may wish to print it and keep a copy in their temporary file/notebook. **NOTE:** Tricare is very time sensitive. Please email the completed Tricare Update to the OA within **3 days** of receiving it.

Evaluations in the Schools, EI, and Clinic: Our goal is that three weeks or less will pass between the date of the e-referral and the completion and delivery of the evaluation.

Performing Evaluations

Evaluations should be performed by therapists per professional standards for speech, occupational, and physical therapy. Requests by the referral sources for specific information and standardized test scores should also be considered.

Documentation of Evaluations

- ✓ Typed or Dictated/transcribed/reviewed
- ✓ First page only must be on Sumlar Therapy letterhead
- ✓ Title: (Physical, Occupational, Speech) Therapy Evaluation (centered, bold, on first page)
- ✓ Primary Information on first page, under title; aligned on left, in bold, the minimum following information is the required:

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- **Name** (always first)
 - **DOB** (always second)
 - **Program/Place of Service**
 - **Date of Evaluation** (always last)
- ✓ Secondary Information: Please include other information when appropriate, including but not limited to:
- **Classroom Teacher:**
 - **School/System:**
 - **Physician:**
 - **Parents:**
 - **Grade:**
 - **Diagnosis:** (only when documented and provided by a physician)
- ✓ Pages 2 through the last page should be on plain paper, and have the
Name,
Date of Report,
Discipline (PT, OT, ST), and
Page Number as a header

Insert your e-signature, save and PDF your document for security purposes before emailing.

Saving your Evaluations: Please save your evals using the following format: patient's last name, patient's first name, discipline, and date in six digit format.
Example: Doe, John PT Eval 081009

TYPES OF EVALUATIONS

1. School Initial Evaluations

- Background Information and Clinical Information, in whatever format the therapist desires
- Proposed IEP Goals for School Year 20XX—20XX:
 - a. Annual Goal (To be evaluated by observation)
 - b. Benchmarks
- Present Level of Performance (summarization of current level in regard to proposed goals—the teacher may use the information in this paragraph in the IEP)
- Recommendations, including frequency and duration of therapy session, suggestions of carryover or equipment, etc.

Email the evaluation to the teacher and cc the OA, along with the cover letter. This letter explains to the IEP holder that she should share a copy of the evaluation with the parents,

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enter your goals and therapy frequency (amend the IEP) into the SETS program if you have recommended therapy, and should notify you of a meeting should one take place to amend the IEP, and that you will not start therapy until the IEP has been amended.

2. School Annual Reassessments

Each student should have a re-evaluation annually, prior to the new IEP being developed. Each re-assessment should follow the above guidelines for an initial evaluation, and should also include a section titled

- Review of IEP Benchmarks for the School Year 20XX-20XX in which you clearly state whether or not the goal was met. This section precedes your proposed annual goal and benchmarks for the next school year.

Email the evaluation to the teacher and cc the OA. The teacher will use this information to prepare the IEP for the next school year (or whatever time period the school has chosen). Do NOT change your goals or frequency at the time of your eval.

Remember—this evaluation and recommendations are for the new IEP, and cannot begin until the new IEP is in place.

3. EI Initial Evaluations

- Background Information and Clinical Information, in whatever format the therapist desires
- Proposed Long-Term and Short-Term Goals
- Recommendations, including frequency and duration of therapy session, suggestions of carryover or equipment, etc.

Email the evaluation to the IFSP holder (case manager) and cc the OA, along with the cover letter. This letter explains to the case manager that she should share a copy of the evaluation with the parents, amend the IFSP to allow for therapy frequency if you have recommended therapy, and that you will not start therapy until the IFSP has been amended. Print a copy for your use.

4. EI Annual Reassessments

Each student should have a re-evaluation annually. Each re-assessment should follow the above guidelines for an initial evaluation, or may be handwritten on the two-part Therapy Progress Note form while in the home, with new goals noted on the EI Record form, dated and signed. Email the evaluation to the IFSP holder (case manager) and cc the OA; or in the case of a handwritten re-eval, may be copied and

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faxed (both the Therapy Progress Note and the EI Record) to the case manager or included in the mailing at the first of the month.

5. Clinic Initial Evaluations

- Background Information and Clinical Information, in whatever format the therapist desires
- Proposed Long-Term and Short-Term Goals
- Recommendations, including frequency and duration of therapy session, suggestions of carryover or equipment, etc.

Email the evaluation to the Office Administrator. You may choose to share a copy of the evaluation with the parents. Print a copy for your use.

6. Clinic Annual Reassessments

Each student should have a re-evaluation annually. Each re-assessment should follow the above guidelines for an initial evaluation.

Email the evaluation to the Office Administrator. You may choose to share a copy of the evaluation with the parents. Print a copy for your use.

Saving your Evaluations: Please save your evals using the following format: patient's last name, patient's first name, discipline, and date in six digit format.

Example: Doe, John PT Eval 081009

Emailing Evaluations: Follow the guidelines below for emailing your evaluations. The manner in which you email and label your evaluations is important to the people who receive them, as they then have a job to do, including printing, saving the attachments, and maintaining a history of the emails.

As soon as they are saved and PDF'd, all evaluations need to be emailed to an interested party, as follows:

Clinic evals should be emailed to the OA (one eval attached per email). Subject line should include the patient's name, discipline (PT, OT, ST), and the word "Eval." Tricare evals should be noted in the subject line, due to their time sensitivity. You may use a high priority indicator when emailing Tricare evals.

School evals should be emailed to the IEP holder and cc'd to the OA (one eval attached per email). Subject line should include the patient's name, discipline and

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the word "Eval." Other parties can also be cc'd at the same time, such as a therapist assistant, or a special education director.

Early Intervention evals should be emailed to the IFSP holder and cc'd to the OA (one eval attached per email). Subject line should include the patient's name, discipline and the word "Eval." Other necessary parties can also be cc'd at the same time.