

Physical Therapy Documentation Cheat Sheet: Best Practices

1. Be Timely. Document during or immediately after patient interaction to ensure accuracy and detail.
2. Be Detailed. Include specific measurements, patient statements, and observed outcomes.
3. Use Standard Terminology. Employ universally recognized terms and abbreviations to ensure clarity.
4. Stay Objective. Focus on factual, measurable data derived from assessments and observations.
5. Set Clear Goals. Document specific, measurable, achievable, relevant, and time-bound (SMART) goals.
6. Note Progress. Clearly indicate any changes in the patient's condition and progress towards goals.
7. Include Rationale. Justify the chosen treatment methods and any changes in the plan.
8. Ensure Confidentiality. Always adhere to HIPAA guidelines to protect patient privacy.
9. Review and Revise. Regularly review notes for completeness and accuracy and amend as needed.
10. Educate and inform. Document any patient education provided and their understanding of it.