# 01 Narrative (Note)

Last Modified on 08/16/2024 11:26 am EDT

**Purpose:**

To guide therapists on what to document in the narrative coordination note during an assessment visit.

**Question Intent:**

Narrative notes are required on all therapy assessment visits at Evaluation or Start of Care. This provides a concise summary of the patient's history and assessment presentation and is a beneficial Note for all disciplines to review.

Looking at Medicare Benefit Policy Manual Chapter 7 - Home Health Services, the narrative helps to paint the picture of why the patient requires skilled therapy and relays that "for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record."

This is essential in Restorative Therapy documentation.

NOTE - see the Maintenance Therapy article to see how Interventions/Goals should be utilized for Maintenance Therapy patients.

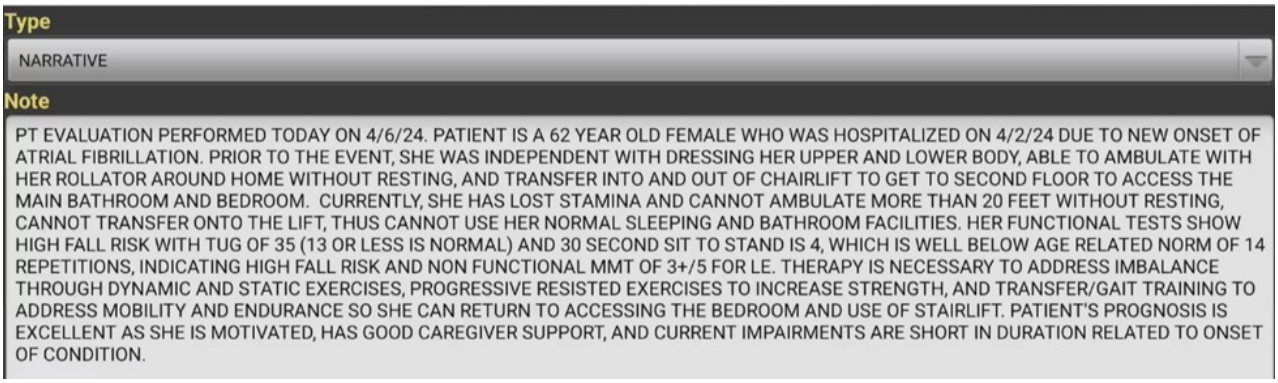
**Response-Specific Instructions:**

At SOC (00) and Evaluation (01) visits, the therapist will add a narrative after the completion of their visit note. Here are the key elements of a narrative note:

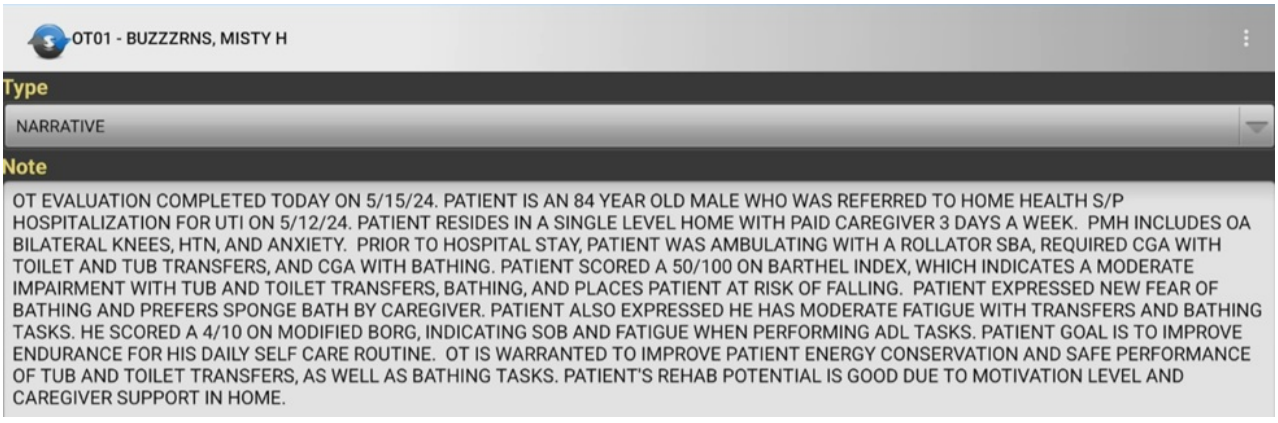
1. **Reason for Referral**-Why was the patient referred by a physician or representative to home health? If they were a previous patient, what has changed or exacerbated?
2. **Diagnosis and or relevant medical history/conditions to show complexity** - Supports skilled need.
3. **Prior Level of Function** – must know what this patient looked like just before decline in function. This is a critical element to make the case.
4. **Patient Goal** – Must be reasonable!
5. **Abnormal objective data to support argument** – Come from specifical functional tests and or objective measures – know the out of parameter norms / age related norms.
6. **Current level of Function** - Specific examples unique to this patient – do not underestimate the importance of this in making a specific case.
7. **Plan** – What will the Therapist do to address the impairments identified?

Below are examples of what to document in the HCHB narrative section for an initial assessment visit. Each discipline is listed.

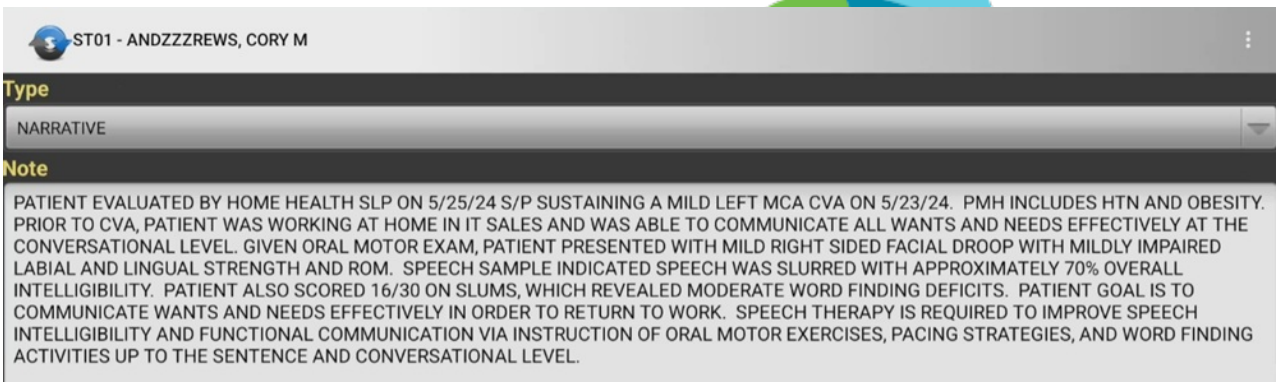
**Physical Therapy**




**Occupational Therapy**




**Speech Therapy**

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