Physical Therapy Plan Of Care/Treatment

Assessment
Rehab potential for stated goals:  □ Good  □ Fair  □ Poor
□ Begin PT  □ Continue PT  □ Evaluation only  □ Equipment needs
□ Consult other services

Problems:
1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________
5. __________________________________________
6. __________________________________________

Goals:
resolved within ______ weeks
resolved within ______ weeks
resolved within ______ weeks
resolved within ______ weeks
resolved within ______ weeks
resolved within ______ weeks

Plan
□ Evaluate this visit, then:  □ Reassess in ______ weeks  □ D/C after goals are met
□ Therapeutic exercises  □ Strength  □ Flexibility/ROM  □ Balance  □ Coordination/Motor Skills  □ Muscle Re- ed
□ Inhibit  □ Facilitate

□ Establish or upgrade the home exercise program

□ Bed mobility training  □ Rolling  □ Scooting  □ Supine--Sit
□ Transfer training  □ Sit--Stand  □ Level surface  □ Unlevel surface  □ Commode/Shower  □ Car  □ Floor--Stand
□ Hoyer lift
□ Wheelchair training
□ Gait training  Weight bearing____ (R/L)  Assistive device:  □ None  □ Standard walker  □ Wheeled walker
   □ Platform walker (R/L)  □ Hemi-walker  □ Axillary crutches  □ Forearm crutches  □ Large base quad cane
   □ Small base quad cane  □ Straight cane
□ Terrain:  □ Even surface  □ Uneven surface  □ Incline/decline  □ Steps

□ Balance activities

□ Modalities
□ Other

□ Vital signs prn
□ Discharge plan

Frequency and duration of services
□ Orders to be continued into the next recertification period of ______/_____/______ to ______/_____/______

Employee Signature: __________________________________________ Date: ______/_____/______ Time: ______ AM/PM

V.O. Physician's Name: __________________________________________ Date POC Returned to HHA: __________________________

(Based area to be completed by clerical staff)

Physician Signature: __________________________________________ Date: ______/_____/______

Patient Name: __________________________________________ Patient ID No.: __________________________ Date: ______/_____/______

Make 2 copies. File one copy on the clinical record until signed original is returned from the physician. Send original along with one copy to the physician. Designate the physician's copy by writing. File signed original on the clinical record upon return from the physician.