UNIVERSITY OF VIRGINIA HEALTH SYSTEM

0300006

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

OUTPATIENT PHYSICAL THERAPY PLAN OF CARE

Patient's Name: _____ DOB: _____

Date of Evaluation/Plan of Care Established: _____

Date Treatment Initiated: _____

Referring Physician: _____

Treatment Goals:

Treatment Frequency: _____

Planned Therapy Interventions:

☐ Therapeutic exercise – Strengthening / ROM	☐ Patient / family education – Home exercise program	☐ Flexibility / stretching
☐ Orthotics / casting	☐ Therapeutic activities	☐ Endurance training
☐ Aquatic Therapy	☐ Equipment evaluation	☐ Balance Activities
☐ Strengthening	☐ Transfer training	☐ Modalities:
☐ Neuromuscular Re-ed	☐ Posture / body mechanics	☐ Other

Requesting Therapist:

Signature: _____ Date: _____

Printed Name: _____

Referring Physician:

I certify the need for these services under this plan of treatment.

Signature: _____ PIC: _____ Date: _____

Printed Name: _____