Hand Therapy Treatment Plan

☐PT ☐OT **Date of Submission** ___/___/____

Landmark Healthcare, Inc. FAX (888) 565-4225 ☐ Initial Care (1st request) ☐ Continuing Care ☐ Retrospective Care (treatment delivered in past)

COMPLETE FOR HAND, WRIST AND ELBOW DIAGNOSES ONLY. IF BILATERAL USE EFORM @ WWW.LMHEALTHCARE.COM

Patient Information – All sections must be completed

Patient Last Name, First Name	Gender ☐ M ☐ F	Age	Date of Birth	Mailing Address, City, State Zip Code

Member ID	Payer Name	Subscriber Last Name, First Name	Phone ( )

Therapist Information – All sections must be completed

Therapist Last Name, First Name	Group or Facility Name	Provider ID or TIN

Provider/Group Address, City, State Zip Code	Phone ( ) Fax ( )	Provider NPI

Diagnosis – The primary diagnosis must be completed

Primary ICD-9	Description	Pain Scale /10	% of Time	Secondary ICD-9	Description	Pain Scale /10	% of Time

Clinical Findings – All sections must be completed

Start date for this treatment plan / /	Date current objective findings obtained / /	Date of initial evaluation / /	Date of onset / /

Mechanism of Onset ☐ Acute Trauma ☐ Worsening of prior ☐ Gradual onset ☐ Other:

Total visits delivered to date

Date of Surgery for Primary Dx: _____/_____/_____ ☐ N/A

Type:

Restrictions ☐ None ☐ Passive motion only ☐ Lifting ☐ Active assistive motion ☐ Other: ☐ Repetitive motion

Co-morbidities ☐ None ☐ Rheumatoid arthritis ☐ Diabetes ☐ Obesity ☐ CVA ☐ MS ☐ Other:

Presence of clinical red flags ☐ Y ☐ N

Altered Sensation ☐ None ☐ Describe:

Tests ☐ N/A

	Pos	Neg

Hand Function

	Interpretation	Recommendation
Power grip lbs: /		
Lateral pinch lbs: /		
3-Jaw grip lbs: /		
Other: /		

Orthoses ☐ N/A

Hand Range of Motion ☐ N/A ☐ WNL ☐ Right ☐ Left **If bilateral use Landmark Connect eForm @ www.LMHealthcare.com**

Finger	Thumb		Index Finger		Middle Finger		Ring Finger		Small Finger	
Joint	Flex	Ext	Flex	Ext	Flex	Ext	Flex	Ext	Flex	Ext
MCP										
PIP										
DIP										
TAM										

Wrist/ Elbow ☐ N/A ☐ WNL	ROM Right	ROM Left	Strength Right	Strength Left
Wrist flexion				
Wrist extension				
Ulnar Deviation				
Radial Deviation				
Supination				
Pronation				
Elbow flexion				
Elbow extension				

Function using Revised Patient Specific Functional Scale List and score at least 3 activities that the patient reports that s/he is unable to perform or has most difficulty performing due to the chief complaint. 0 = no difficulty 10 = unable to perform Date: / /

#	Description of activity		#	Description of activity	
1	Open tight/new jar	Score:	6	Make a bed	Score:
2	Write	Score:	7	Carry shopping bag	Score:
3	Turn a key	Score:	8	Button/tie/zip	Score:
4	Prepare meals	Score:	9		Score:
5	Push/pull open door	Score:	10		Score:

Functional Goals

Home management program

☐ No home management program

☐ Initiated home management program

☐ Independent with or without family assistance

Comments/ barriers to independence in the home management program ☐ Y ☐ N If yes, explain below:

Signature Professional designation (PT/OT) Date