THERAPY TREATMENT PLAN

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Please complete the following: ❑ PHYSICAL MEDICINE/REHABILITATION ❑ MANIPULATION ❑ OCCUPATIONAL ❑ RESPIRATORY ❑ SPEECH

TREATMENT PLAN (check one) ❑ Initial (therapy begins) ❑ Continuation of Care (circle one) 1 2 3	**PLAN** (check one) ❑ Indemnity ❑ POS ❑ PPO ❑ HMO ❑ Other: **DATE OF ORIGINAL ONSET/INJURY** (mm/dd/ccyy): **Patient's Occupation:**

Patient's Name (First, Middle Initial, Last):	**Patient's Sex** ❑ M ❑ F	**Insured's ID Number:**	**Insured's Name if not patient:**	**Patient's Date of Birth:**
Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other:		**Self Referred** ❑ Yes ❑ No	**Ordering Physician (First, Last Name):**	**Phone Number:** ( )
Date of PCP Referral:	**Patient Case Managed:** ❑ Yes ❑ No	**Notified patient's PCP:** ❑ Yes ❑ No	**Full Name of PCP (First, Last):**	**Phone Number:** ( )

Diagnosis: ICD-9 code(s): _____

Procedure: CPT code(s): _____

Related Surgery: ❑ No ❑ Yes – Type: _____ Date: _____

Condition Type: ❑ Acute ❑ Chronic **Condition Origin:** ❑ New ❑ Recurrent ❑ Exacerbated – Date: _____

If Exacerbated, describe Nature of Exacerbation: _____

Comorbidities impeding recovery: _____

Prior Level of Function: _____

Chief Complaint: _____

Problems:

❑ Pain – Rating: _____ Scale rating 0 – 10 (0 = no pain, 10 = excruciating pain)

❑ Current ROM to deficit area(s) [use degrees] – _____ Specify area(s) _____

❑ Loss of Strength: _____ Scale rating 1 – 5 (1 = no strength, 5 = normal strength)

❑ Loss of Normal ADLs (list): _____

❑ Additional Exam Findings: _____

❑ Diagnosis Test Results: _____

❑ Respiratory _____

❑ Other (include gait abnormalities, use of devices, cognitive status, difficulty breathing or swallowing, vocal quality, etc.): _____

❑ Changes since last authorization: _____

Date of next doctor's appointment: _____

Goals:

Short Term	**Long Term**
❑ Reduce Pain – Scale Rating: _____	❑ Return to Work: _____
❑ Improve ROM – Specify area (use degrees): _____	❑ Restore to Level of Independence w/ADLs (list): _____
❑ Improve Strength – Specify area (grade improvement): _____	❑ Improve Ambulation
	❑ Use of Device
	❑ Other: _____

Treatment Plan (list current modalities/procedures): _____

AUTHORIZATION #:	**Number of Visits/Services Authorized:**	**Last Covered Day:**	**Issued Date:**

Receipt of an Authorization does NOT mean that the requested service is covered under the patient's benefit plan or that the patient is eligible to receive such services.

Number of visits completed to date: _____

❑ Initial Start Date: _____ Frequency: _____ times/wk x _____ weeks. Estimated Discharge Date: _____

❑ Continuation of Care Start Date: _____ Frequency: _____ times/wk x _____ weeks. Estimated Discharge Date: _____

Progress (Continuation of Care Plan Only): Patient Improved: ❑ 10 – 25% ❑ 25 – 50% ❑ 50 – 75% ❑ 75 – 100%

Billing Provider's Name and Facility Location (PLEASE PRINT)	**Billing Provider Number**	**Provider's Fax #** ( ) **Provider's Phone #** ( )	**Date**

Performing Provider's Name (PLEASE PRINT)	**PROVIDER:** ❑ MD ❑ DO ❑ DC ❑ PT ❑ OT ❑ DPM	**ADJUNCTIVE LICENSE** ❑ YES ❑ NO	**Signature**