

PLAN OF CARE

Patient's Name : _____ Date of Birth : _____ Phone : _____

Medical Diagnosis : _____ Date of Onset : _____ Date of Surgery : _____

Therapy Diagnosis :	723.1 Cervical Spine Pain	719.43 Wrist Pain	718.44 Hand Contractures	781.2 Abnormality of Gait
	723.4 Cervical Radicular	719.53 Wrist Stiffness	719.44 Hand Pain	781.3 Lack of Coordination
	724.2 Lumbago	719.41 Shoulder Pain	719.55 LE Leg Stiffness	_____
	724.3 Sciatica	719.51 Shoulder Stiffness	719.47 Ankle/Foot Pain	_____
	724.4 Lumbar Radicular	719.42 Elbow Pain	719.57 Ankle Stiffness	_____
	729.5 Pain in Limb	719.52 Elbow Stiffness	719.54 Finger Stiffness	_____
	718.49 Cont in Joint -Multi	719.46 Knee Pain	728.85 Muscle Spasms	_____
	719.49 Pain in Joint -Multi	719.56 Knee Stiffness	728.87 Muscle Weakness	_____

Treatment Prescribed : Evaluate and Treat as indicated OT Splint fabrication _____

- | | | |
|----------------------------------|--------------------------------|--|
| Continue established program | Strengthening | Neuromuscular Reconditioning Program |
| Modalities as indicated | Laser Therapy (LLLT) | Iontophoresis (30cc Dexamethazone .4% called in) |
| Dynamic Stabilization Exercises | Aquatic Rehab (Heated Pool) | MMI / Workers Comp Impairment Rating |
| Home Exercise Instruction | General Reconditioning | Adaptive Equipment / Cognitive Training |
| Work Conditioning / Hardening | FCE (Functional Capacity Eval) | Other _____ |
| Sub-Acute Cardiac Reconditioning | Other as indicated : _____ | |

Frequency : *TIW BIW Daily Other* _____ Duration : **2 4 6 8 10 12** _____ wks

Special Instructions or Precautions : _____

MEDICAL SUMMARY

Related Medical Findings : _____ Medications : See attachment in chart _____

Summary of Previous Treatment related to this Diagnosis : _____

- Goals for Rehab : Short Term To be met in _____ wks**
- | | | |
|---|---|---|
| <input type="checkbox"/> Decrease Pain from _____ to _____ | <input type="checkbox"/> Increase subjective ADL tolerance | <input type="checkbox"/> Abolishment of Active Trigger Points |
| <input type="checkbox"/> Demonstrate compliance with Home Program | <input type="checkbox"/> Demonstrate Proper Body Mechanics | <input type="checkbox"/> Reduce / Abolish Swelling / Tenderness |
| <input type="checkbox"/> Increase Flexibility _____ | <input type="checkbox"/> Express Understanding of Precautions | <input type="checkbox"/> Gait with _____ device _____ |
| <input type="checkbox"/> Increase Strength _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

- Goals for Rehab : Long Term To be met in _____ wks**
- | | | |
|--|--|--|
| <input type="checkbox"/> Decrease Pain from _____ to _____ | <input type="checkbox"/> Subj Perceived Normality to _____ % | <input type="checkbox"/> Abolish radicular symptoms |
| <input type="checkbox"/> MMI, Progress to Ind. Maintenance Program | <input type="checkbox"/> Demonstrate Proper Body Mechanics | <input type="checkbox"/> Return to work/activity \bar{c} or \bar{s} restrictions |
| <input type="checkbox"/> Increase Flexibility _____ | <input type="checkbox"/> Independent with Home Program | <input type="checkbox"/> Gait with _____ device safely in community |
| <input type="checkbox"/> Increase Strength _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Rehab Potential: Good Fair Poor + - Plan to Re-Evaluate by Physician : _____

Patient aware of diagnosis : Yes _____ No _____ Prognosis : Yes _____ No _____ Comments _____

Therapist developing this POC _____ Plan Established / Start of Care Date _____

I CERTIFY THAT THE ABOVE SERVICES ARE REQUIRED BY THIS PATIENT ON AN OUT-PATIENT BASIS.

Referring/Treating Professional's Signature : _____ Date of Approval : _____

Printed Name of Referrer : _____ Office Fax # : _____

Referrer must be authorized by the state of Texas , and by their specific licensure board to refer such services as outlined above.