

www.HulseyTherapy.com

PLAN OF CARE

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

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

Therapy Diagnosis :

<input type="checkbox"/> 723.1 Cervical Spine Pain	<input type="checkbox"/> 719.41 Shoulder Pain	<input type="checkbox"/> 719.49 Pain in Joint –Multi	<input type="checkbox"/> 728.87 Muscle Weakness
<input type="checkbox"/> 723.4 Cervical Radicular	<input type="checkbox"/> 719.51 Shoulder Stiffness	<input type="checkbox"/> 719.55 LE Leg Stiffness	<input type="checkbox"/> 728.85 Muscle Spasms
<input type="checkbox"/> 724.2 Lumbago	<input type="checkbox"/> 719.42 Elbow Pain	<input type="checkbox"/> 719.47 Ankle/Foot Pain	<input type="checkbox"/> _____
<input type="checkbox"/> 724.3 Sciatica	<input type="checkbox"/> 719.52 Elbow Stiffness	<input type="checkbox"/> 719.57 Ankle Stiffness	<input type="checkbox"/> _____
<input type="checkbox"/> 724.4 Lumbar Radicular	<input type="checkbox"/> 719.46 Knee Pain	<input type="checkbox"/> 781.3 Lack of Coordination	<input type="checkbox"/> _____
<input type="checkbox"/> 729.5 Pain in Limb	<input type="checkbox"/> 719.56 Knee Stiffness	<input type="checkbox"/> 781.2 Abnormality of Gait	<input type="checkbox"/> _____

Treatment Prescribed :

<input type="checkbox"/> Evaluate and Treat as indicated	<input type="checkbox"/> OT Splint fabrication _____	
<input type="checkbox"/> Continue established program	<input type="checkbox"/> Strengthening	<input type="checkbox"/> Neuromuscular Reconditioning Program
<input type="checkbox"/> Modalities as indicated	<input type="checkbox"/> Laser Therapy (LLLT)	<input type="checkbox"/> Iontophoresis [30cc Dexamethazone .4% called in]
<input type="checkbox"/> Dynamic Stabilization Exercises	<input type="checkbox"/> Aquatic Rehab (Heated Pool)	<input type="checkbox"/> MMI / Workers Comp Impairment Rating
<input type="checkbox"/> Home Exercise Instruction	<input type="checkbox"/> General Reconditioning	<input type="checkbox"/> Adaptive Equipment / Cognitive Training
<input type="checkbox"/> Work Conditioning / Hardening	<input type="checkbox"/> FCE (Functional Capacity Eval)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cardiac Reconditioning	<input type="checkbox"/> 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 : _____

Summary of Previous Treatment related to this Diagnosis : _____

Medications : See attachment in chart -or- _____

Goals for Rehab : *Short Term*

- Decrease Pain from ____ to ____
- Dynamic Strength/Stabilization to ___/5
- Flexibility of _____ to _____
- Increase Micro-Fet of _____ to _____

To be met in _____ wks

- Increase ADL tolerance
- Demonstrate Proper Body Mechanics
- Express Understanding of Precautions
- _____
- Abolishment of Active Trigger Points
- Reduce / Abolish Swelling
- Gait with _____ device _____
- _____

Goals for Rehab : *Long Term*

- Decrease Pain from ____ to ____
- Dynamic Strength/Stabilization to ___/5
- Flexibility of _____ to _____
- Increase Micro-Fet of _____ to _____

To be met in _____ wks

- Return ADL tolerance to _____ %
- Demonstrate Proper Body Mechanics
- Independent with Home Program
- _____
- Abolish radicular symptoms
- Return to work/activity \bar{c} or \bar{s} restrictions
- Gait with _____ device safely community
- _____

Rehab Potential: Good Fair Poor + - Plan to Re-Evaluate in : _____ wks

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

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

Referring/Treating Professional's Signature : _____ Start of Care Date : _____

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.