HULSEY THERAPY SERVICES
Rehab & Sports Medicine
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PLAN OF CARE

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

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

Therapy Diagnosis : (*Updated ICD-10 Diagnosis Codes*) Involved Side : _____

_____ _____ _____ _____ _____ _____

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

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

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***

- ☐ Decrease Pain from ____ to _____
- ☐ Demonstrate compliance with Home Program
- ☐ Increase Flexibility _____
- ☐ Increase Strength _____
- ☐ Increase subjective ADL tolerance
- ☐ Demonstrate Proper Body Mechanics
- ☐ Express Understanding of Precautions
- ☐ _____
- ☐ Abolishment of Active Trigger Points
- ☐ Reduce / Abolish Swelling / Tenderness
- ☐ Gait with _____ device _____
- ☐ _____

Goals for Rehab : ***Long Term*** ***To be met in _____ wks***

- ☐ Decrease Pain from ___ to ____
- ☐ MMI, Progress to Ind. Maintenance Program
- ☐ Increase Flexibility _____
- ☐ Increase Strength _____
- ☐ Subj Perceived Normality to ____ %
- ☐ Demonstrate Proper Body Mechanics
- ☐ Independent with Home Program
- ☐ _____
- ☐ Abolish radicular symptoms
- ☐ Return to work/activity $\overline{c}$ or $\overline{s}$ restrictions
- ☐ Gait with _____ device safely in community
- ☐ _____

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.