Therapy Station
Progressing towards Independence

PHYSICAL THERAPY RE-EVALUATION

AUTHORIZATION PERIOD: _____________TO____________

Patient: ____________________________ Examiner: _______________________
DOB: ___________ DOE: ___________________________
CA: ___Years_____Month Diagnosis: ______________________
Parents: ____________________________ Physician: _______________________

Medical/Background History: ____
____
____
____

Previous Goals and Status:
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Assessment: ____
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New Goals: The patient will be able to**:**
1.____
____
2.____
____
3.____
____
4.____
____

12760 Westwood Lakes Blvd. Tampa. Fl 33626. PH: (813) 855-9791 Fax: (813) 814-4520

❖ Physical Therapy ❖ Occupational Therapy ❖ Speech Therapy

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Patient Name:________________________

PATIENT PLAN OF CARE

Recommended Modalities:

__	A/AA/PROM	__	Prosthetic Training	__	Tissue Mobilization	___	Gait Training
__	Enudrance	__	Neuromuscular	__	Therapeutice Exercise	___	NDT
__	Home Program	__	Transfer Training	__	Care giver training	___	Wound care

Recommended Treatment sessions:

It is recommended that the above-mentioned patient receive ______ physical therapy treatment sessions, up to _______minutes with in ________ months to maximize functional abilities.

Justification for longer or no treatment session recommended: *(please write reason if patient require more than 30 minutes per treatment session)*

____

____

____

_________________________RPT/L ___________

Physical Therapist Date

Dear Physician:

Thank you for the referral. Please sign and return the treatment plan to Therapy Station. Your signature will convert this report into a prescription.

I certify that the above treatment plan is medically necessary and valid.

________________________________ _____________

Physician's Signature Date

____

Medipass Auth. Number (if applicable)

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