



Therapy Station

Progressing towards Independence

PHYSICAL THERAPY EVALUATION

AUTHORIZATION PERIOD: _____ to _____

Patient: _____

Examiner: _____, RPT/L

DOB: _____

DOE: _____

CA: ___ Years ___ Month

Diagnosis: _____

Parents: _____

Physician: _____

Medical/Background History:

Neuromuscular control: (ROM, Tone, Strength, Reflex, Coordination, and Balance)

Gross Motor: (Rolling, Crawling, Standing, Kicking and Jumping)

Functional Mobility: (Bed mobility, Gait, Wheelchair, and Transfers)

Splint/Wheel chair: _____

Assessment: _____



Patient Name: _____

PATIENT PLAN OF CARE

Recommended Modalities:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> A/AA/PROM | <input type="checkbox"/> Prosthetic Training | <input type="checkbox"/> Tissue Mobilization | <input type="checkbox"/> Gait Training |
| <input type="checkbox"/> Enudrance | <input type="checkbox"/> Neuromuscular | <input type="checkbox"/> Therapeutice Exercise | <input type="checkbox"/> NDT |
| <input type="checkbox"/> Home Program | <input type="checkbox"/> Transfer Training | <input type="checkbox"/> Care giver training | <input type="checkbox"/> 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)*

Recommended Equipment/Splint/Braces (Reason):

Recommended Other Therapies: Occupational Therapy / Speech Therapy

Goals: The patient will be able to:

1. _____

2. _____

3. _____

4. _____

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)