matrix
The Primary Source for Home Care

Physical Therapy Plan of Care

PHYSICIAN PLAN OF CARE - CHANGE AND ADDITIONAL ORDERS

Patient/Client Name: _____ Date: _____

Patient/Client Address: _____

Physician's Name: _____

Physician's Phone: _____ Fax: _____

County: _____

Dear Doctor:
The orders shown below are being forwarded for your signature to authorize your verbal orders given on this date. Please sign and return this form within three (3) days for our patient's chart. *Thank you for the referral of your patient for services.*

☐ Initial Evaluation ☐ Routine Visit
☐ Frequency/Duration _____ AS OF Date ___/___/___

☐ PT Evaluation
Date: ___/___/___
☐ Therapeutic Exercises
May include: ☐ active, ☐ active-assisted, ☐ passive, ☐ muscle stretching, ☐ resisted, ☐ PRE, ☐ PNF, ☐ Williams Flexion, ☐ Codmans Shoulder
☐ Transfer Training
☐ Home Exercise Program
☐ Gait Training
with (device)_____ at_____(weight-bearing status) and _____ (distance). Progress to _____at_____ and_____when medically indicated

☐ Cardiopulmonary Treatment
May include ☐ breathing exercises, ☐ postural drainage, ☐ cardiopulmonary conditioning, ☐ chest physiotherapy
☐ Ultrasound
at_____output for _____ (time) to _____ _____(affected area)
☐ Electro Treatment
☐ EMS, ☐ MEDCO, ☐ FES
☐ HVGS, ☐ TENS for_____ (time) to _____(affected area)
☐ Prosthetic Training
May include ☐ Stump conditioning ☐ muscle str, ☐ ROM ☐ Gait training with/without prosthesis

☐ Muscle Re-education
☐ Management & Evaluation of Patient Care Plan
☐ Other
☐ Balance/coordination exercises
☐ ADL training
☐ Safety precaution instruction
☐ Body mechanics instruction
☐ Bed mobility instruction
☐ Instruction/use of heat
☐ Paraffin
☐ _____

GOALS: Rehab Potential: ☐ Good ☐ Fair

1. Patient will demonstrate increased muscle strength of_____(muscle(s)) to_____(grade) within _____weeks.
2. Patient will demonstrate increased ROM of_____ (joint(s)) to_____ (ROM) within_____weeks.
3. Patient will demonstrate improved sitting/standing balance to _____ (grade) within _____weeks.
4. Patient will demonstrate improvement of_____transfers to _____(level of assist) within_____weeks.
5. Patient/Caregiver will demonstrate appropriate use of _____(assistive device/DME) within _____days/weeks.
6. Patient will demonstrate improved gait to _____feet with_____device within_____weeks.
7. Patient will verbalize a consistent level of pain control as evidenced by a pain range to be within (scale 1-10)_____ to_____within_____weeks.
8. Patient will have improved endurance to _____(grade) within_____weeks.
9. Patient/Caregiver will be independent in home exercise program within _____ weeks.
10. Patient/Caregiver will verbalize understanding of discharge plan within _____days/weeks.
11. Other: _____

Therapist's Signature: _____ Date: ___/___/___

Physician's Signature: _____ Date: ___/___/___