PATIENT NAME: LAST, FIRST

MEDICAL RECORD NUMBER

THERAPY PLAN OF CARE

Date	Problem	Needs	Interventions / Treatments	Goals / Expected Outcomes

See attached evaluation.

See attached Medication profile

Diagnosis: _____

Rehabilitation potential: _____

Frequency/duration: PT/OT/ST _____

Discharge plans: _____

Patient and/or family/caregiver is involved in and agrees with the plan of care. ❑ Yes ❑ No

Employee Signature/Credentials **Date**

Physician's Name: _____

Address: _____

Phone: _____

I certify that this patient is confined to his/her home and needs therapy services.

Physician's signature **Date**

Please sign AND date. No rubber stamps.

OFFICE RECORD