PHYSICAL THERAPY CARE PLAN

SOC DATE____/____/____

Primary Diagnosis:_____ **Onset Date:**____/____/____

Treatment Diagnosis/Problem Areas:_____

HOMEBOUND REASON:

- ❑ Needs assistance for all activities
- ❑ Residual weakness
- ❑ Requires assistance to ambulate
- ❑ Unable to safely leave home unassisted
- ❑ Dependent upon adaptive device(s)
- ❑ Confusion, unable to go out of home alone
- ❑ Severe SOB, SOB upon exertion
- ❑ Medical restrictions
- ❑ Other (specify):_____

Frequency and Duration:_____

PHYSICAL THERAPY INTERVENTIONS

- ❑ Establish HEP: ❑ Given to Pt ❑ In Chart
- ❑ Patient/Family/Caregiver Education
- ❑ Adaptive Equipment Training
- ❑ Therapeutic Exercise
- ❑ Neuro-Muscular Re-education
- ❑ Gait Training
- ❑ Modalities: ❑ TENS ❑ Ultrasound ❑ E-stim ❑ Heat ❑ Ice
- ❑ Balance
- ❑ Pulmonary PT
- ❑ Orthotic Fitting/Fabrication/Training
- ❑ Prosthetic Fitting/Febrication/Training
- ❑ Functional Mobility
- ❑ Other:_____

GOALS/OUTCOMES: Patient/Therapist identified functional based goals (areas identified in evaluation)

Functional Goal Area Identified at Eval:	Functional Short Term Goal #1: Measurable and data by:____/____/____	Functional Long Term Goal #1: Measurable and date by:____/____/____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #2: Measurable and date by:____/____/____	Functional Long Term Goal #2: Measurable and date by:____/____/____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #3: Measurable and date by:____/____/____	Functional Long Term Goal #3: Measurable and date by:____/____/____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #4: Measurable and date by:____/____/____	Functional Long Term Goal #4: Measurable and date by:____/____/____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #5: Measurable and date by:____/____/____	Functional Long Term Goal #5: Maasurable and date by:____/____/____

Adaptive equipment needs identified? ❑ Yes ❑ No If Yes (specify):_____

Patient/Family/Caregiver aware and in agreement of POC? ❑ Yes ❑ No If No (specify):_____

Discharge Plan: ❑ When goals are met ❑ Other (specify):_____

Comments:_____

Demonstrates Rehab Potential: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Patient demonstretes potential for continued gains towards a greater level of functional independence and will benefit from continued Physical Therapy Services to address deficit areas impacting his/her function. Please see Physical Therapy Evaluation and Plan of Care for further detailed information regarding current functional level and areas of focus.

Plan developed by:_____ Date:_____

Professional signature/title

Physical Therapy Care Plan and Physician Orders

NOTE: To be used ONLY for Supplemental Orders to Plan of Care/485 for Therapy Services.

When patient under hospice POC, the IDT determines changes to the POC with the medical director and/or attending physician.

Recommended Plan, Outcomes, Frequency & Duration as above.

Verbal orders from physician by:_____ Date:_____

Professional signature/title

Physician signature:_____ Date:_____

Please sign and return promptly

Original - Physician Copy - Clinical Record (until signed original returned)

PATIENT NAME – Last, First, Middle Initial	ID#