THERAPY TREATMENT PLAN

☐ Initial ☐ Revised

Please provide the following information:

Insured's ID (including any letters): _____

Insured's Name (First name, middle initial, last name): _____

Patient's Sex:
☐ Male ☐ Female

Patient's Relationship to Insured:
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient's Date of Birth (MM/DD/YY) _____

Patient's Name (First name, middle initial, last name): _____

Billing Provider ID: _____

Billing Provider Name: _____

The specific modalities/procedures to be used in treatment:
☐ CMT 9894-0-1-2-3 ☐ Mechan. Traction 97012
☐ Ultrasound 97035 ☐ Heat/Cold 97010
☐ Manual Therapy 97140 ☐ Musc. Stim. 97014

Specific Rehab:
☐ Ther. Activities 97530 ☐ Gait Training 97116
☐ Ther. Exercises 97110 ☐ Work Hardening 97545-6
☐ NMR 97112 ☐ ADL 97535 ☐ Aqua. Ther. 97113

Diagnosis:
A. _____ B. _____ C. _____ D. _____
E. _____ F. _____ G. _____ H. _____
I. _____ J. _____ K. _____ L. _____

Degree of Severity (check one): ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe
Condition Type (check one): ☐ Acute ☐ Chronic
Condition Origin (check one): ☐ New ☐ Exacerbation ☐ Recurrence
Date of onset/injury: _____/_____/_____ Referring Physician (if any): _____
Impairment characteristics (check any): ☐ Pain ☐ Range of Motion ☐ Muscle Weakness ☐ Function

Physician examination findings – X-ray or other pertinent findings:

Specific statement of goals:

Short Term: ☐ Minimize pain ☐ Relief of spasms ☐ Increased ROM of affected body part(s) to the fullest functional potential
☐ Reduce swelling ☐ Increased strength and power of the affected body part(s) to the fullest functional potential
☐ Increased tolerance to: _____

Long Term: ☐ Return to independence in ADLs ☐ Improved breathing pattern and control ☐ Demonstrate independence in HEP
☐ Improved overall endurance level ☐ Improved coordination to max potential ☐ Return to independence in ambulation
☐ Increased tolerance to: _____

A reasonable estimate of when the goals will be reached (fill out the appropriate one):

Initial TP Initial treatment date: _____/_____/_____ Estimated completion date: _____/_____/_____
# of treatments per week: _____ # of weeks of treatments: _____

Revised TP Initial treatment date: _____/_____/_____ Estimated completion date: _____/_____/_____
# of treatments per week: _____ # of weeks of treatments: _____

_____ _____
Healthcare Professional Signature Date