Physical Therapy Treatment Plan

eviCore healthcare
FAX (888) 565-4225

Date of Submission ___/___/___
Please check type of care:
☐Initial care ☐Continuing care

INSURED

Patient Last Name	Patient First Name	M.I.	Gender ☐ M ☐ F	Age	Date of Birth (MM/DD/YYYY) _____/_____/_____
Insured I.D. or SSN	Insured Last Name	M.I.	First Name		Patient Phone (area code first)
Patient Address	City			State	Zip Code

PAYOR

Employer Name	Insurance Company	Group Plan # or Union Local (Submit Copy of Patient's Insurance I.D. Card)	
Injury or illness is related to: ☐ Work ☐ Auto ☐ Other	Referring Physician/Practitioner	Doctor License #	Date of Referral _____/_____/_____

PT/OT

Therapist Last Name	Therapist First Name	M.I.	Group Name	Provider/Group ID#
Provider/Group Address	City	State / Zip Code		Phone # ( ) Fax # ( )

PATIENT'S CURRENT MEDICAL HISTORY

Subjective Complaints:

Lost days from work to date _____ Days of work restriction to date _____

Mechanism of Onset for Primary Diagnosis
Date of Onset ___/___/_____ *Date of Initial Evaluation* ___/___/_____
☐ Acute Trauma ☐ Worsening of prior illness/injury
☐ Repetitive Motion ☐ Gradual Onset
☐ Chronic ☐ Other
Description:

Objective Findings *Date Obtained* ___/___/_____
Inspection/Palpation:

Spinal Range of Motion

Cervical ROM		Lumbar ROM
_____°	Flexion	_____°
_____°	Extension	_____°
_____°	R.Lat.Flex	_____°
_____°	L. Lat. Flex	_____°
_____°	R. Rotation	_____°
_____°	L. Rotation	_____°

Extremity Range of Motion *(Circle Painful Tests)*
Extremity: (specify)_____

	Active (Degrees)	Passive (Degrees)	Manual Muscle Test Strength (0-5)
Flex.	R_____/_____L	R_____/_____L	R_____/_____L
Ext.	R_____/_____L	R_____/_____L	R_____/_____L
Abduction	R_____/_____L	R_____/_____L	R_____/_____L
Adduction	R_____/_____L	R_____/_____L	R_____/_____L
Int rotat.	R_____/_____L	R_____/_____L	R_____/_____L
Ext rotat.	R_____/_____L	R_____/_____L	R_____/_____L
Supination	R_____/_____L	R_____/_____L	R_____/_____L
Pronation	R_____/_____L	R_____/_____L	R_____/_____L
L Deviation	R_____/_____L	R_____/_____L	R_____/_____L
R Deviation	R_____/_____L	R_____/_____L	R_____/_____L
Opposition	R_____/_____L	R_____/_____L	R_____/_____L
Plantar flex	R_____/_____L	R_____/_____L	R_____/_____L
Dorsi flex	R_____/_____L	R_____/_____L	R_____/_____L
Eversion	R_____/_____L	R_____/_____L	R_____/_____L
Inversion	R_____/_____L	R_____/_____L	R_____/_____L

Summary of Clinical Findings (Orthopedic, Neurologic, Additional Info.)

Date of first tx at this office for this condition _____/_____/_____ Anticipated Release Date _____/_____/_____

DIAGNOSES

ICD Code:	Description:	Pain Scale (0-10)
1. Primary _____	_____	_____/10
2. Secondary _____	_____	_____/10
3. Additional _____	_____	_____/10
4. Additional _____	_____	_____/10

TREATMENT PLAN

Treatment Goals (Functional Improvement and Outcomes Expected)

Treatment Plan (MM/DD/YYYY)
From ___/___/_____
To ___/___/_____
Anticipated No. of Visits _____

Patient Home Care
☐ Stretching ☐ Exercise ☐ Hot/cold

Complicating Factors *(Check any that apply and /or list)*
☐ Surgery: Date_____/_____/_____
Type _____
Precautions_____
_____
☐ Poor tissue healing such as: pernicious anemia, diabetes, thyroid disease, pregnancy
Other: _____

Activities of Daily Living
Functional Limitations (check all that apply)
☐ Locomotion/movement
- ☐ Bed mobility
- ☐ Transfers (such as moving from bed to chair, from bed to commode)
- ☐ Walking _____(Duration/Distance)
- ☐ Stair climbing

☐ Self-care (such as bathing, dressing, eating, toileting)
☐ Home management (such as household chores, shopping, driving/transportation, care of dependents)
☐ Community and work activities
- ☐ Work/School
- ☐ Recreation or play activity

☐ Lifting/Carrying
- ☐ Overhead _____ lbs.
- ☐ From waist _____ lbs.
- ☐ From floor _____ lbs.

☐ Other _____

I declare that the above information is true and correct to the best of my knowledge. Further, it is my professional judgment that physical therapy is not contraindicated for this patient. If I am required under state law to obtain a prescription prior to rendering this treatment, I have obtained such a prescription in compliance with state law.

Signature_____Date_____