Occupational 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

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 ____

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: ____________________________________

I declare that the above information is true and correct to the best of my knowledge. Further, it is my professional judgment that occupational 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____________________