Treatment plan | *PT/OT/SPT/chiro/acupuncture/naturopath*

PROVIDER: If your assessment form clearly addresses the issues on this form you may submit it instead.

Date of submission ____ /____ /________ **Please check type of care:** ☐Initial care ☐Continuing care

SECTION 1 | *Patient information*

Last name	First name	M.I.	Gender: ☐ M ☐ F	Age	Date of birth (mm/dd/yyyy)
Patient address		City		State	ZIP
Insured I.D. number	Insured last name	Insured first name		M.I.	Phone number
Treating provider name		TIN			Phone number/fax
Provider/group address		City		State	ZIP

SECTION 2 | *Patient's current medical history*

Subjective complaints:

Lost days from work to date: ________ Days of work restriction date: ________

Mechanism of onset for primary diagnosis

Date of onset ____ /____ /________ Date of initial evaluation ____ /____ /________

☐Acute trauma ☐Worsening or prior illness/injury
☐Repetitive motion ☐Gradual onset
☐Chronic ☐Other

Description: ________________________________

Objective findings date obtained ____ /____ /________
Inspection/palpitation

Summary of clinical findings (orthopedic, neurologic, additional info.)

Date of first tx at this office for this condition: ____ /____ /________ Anticipated release date: ____ /____ /________

SECTION 3 | *Diagnosis and treatment plan*

ICD-9 Code	Description	Pain scale (0-10)
1. Primary:		____ /10
2. Secondary:		____ /10
3. Additional:		____ /10
4. Additional:		____ /10

Treatment goals *Functional improvement and outcomes expected*

Treatment plan
From: ____ /____ /________
To: ____ /____ /________
Anticipated # of visits ________
Patient home care:

Complicating factors:

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 activities

☐Lifting/carrying
- ☐Overhead ________ lbs. ☐From waist ________ lbs. ☐From floor ________ lbs.

☐Other ________________________________

SECTION 4 | *Authorization*

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

Signature ________________________________ Date ____________

ODS, P.O. Box 40384, Portland, OR 97204 | **FAX:** 503-243-5105 | **www.odscompanies.com**

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