PHYSICAL THERAPY CARE PLAN

Diagnosis: _____

Frequency and Duration: _____

ORDERS (Mark all applicable with an "X".)

	Evaluation		Balance training/activities		Management and evaluation of care plan		Teach safe/effective use of adaptive/assist device (specify)
	Establish/Upgrade home exercise program		TENS		Pulmonary Physical Therapy	■	
■	❑ Copy given to patient ❑ Copy attached to chart		Ultrasound		Cardiopulmonary PT		Teach safe stair climbing skills
			Electrotherapy		Pain Management		Instruct on safety issues
	Patient/Family education		Prosthetic training		CPM (specify)		Heat/Ice
	Therapeutic exercise		Preprosthetic training		Functional mobility training		Body Mechanics
	Transfer training		Fabrication of orthotic device		Teach bed mobility skills		Other:
	Gait training		Muscle re-education		Teach hip safety precautions		

GOALS

❑ Return to pre-injury/illness level of function within _____ weeks.
❑ Patient will meet maximum rehab potential within _____ weeks.
❑ Return to optimal and safe functionality within _____ weeks.
❑ Demonstrate effective pain management within _____ weeks.

❑ Improve bed mobility to _____ assist within _____ weeks.
❑ Improve bed mobility to independent within _____ weeks.
❑ Improve transfers to _____ assist using _____ within _____ weeks.
❑ Independent with transfer skills within _____ weeks.
❑ Patient to be independent with safety issues in _____ weeks.

❑ Improve wheelchair use to _____ within _____ weeks.
❑ Patient will ambulate with _____ device with ____ assist within _____ weeks.
❑ Patient will be able to climb stairs/uneven surfaces with _____ device with _____ assist within _____ weeks.
❑ Independent with ambulation with _____ device within _____ weeks.
❑ Ambulation endurance will be _____ minutes or _____ feet within _____ weeks.

❑ Increase strength of ❑ R ❑ L UE to _____/5 in _____ weeks.
❑ Increase strength of ❑ R ❑ L LE to _____/5 in _____ weeks.
❑ Improve strength of _____ to _____/5 within _____ weeks.
❑ Increase ROM of _____ joint to _____ degree flexion and _____ degree extension in _____ weeks.
❑ Increase ROM of _____ joint to _____ degree of _____ in _____ weeks.
❑ Demonstrate ROM to WNL within _____ weeks.

❑ Demonstrate proper use of prosthesis/brace/splint within _____ weeks.
❑ Demonstrate proper use of DME within _____ weeks.

❑ Patient will have an increase in Tinetti Balance score to _____/28 within _____ weeks.
❑ Improve balance score to _____ using _____ test.
❑ Other: _____

Rehab. Potential: ❑ Good ❑ Fair ❑ Poor ❑ Other: _____

Discharge Plan: ❑ Patient will be discharged to care of self/caregiver with self/caregiver arranged healthcare
❑ Other: _____

Equipment/Supplies Needed: _____

Additional Information: _____

Care Coordination: ❑ Physician ❑ PT/PTA ❑ OT ❑ ST ❑ SS ❑ SN ❑ Other: _____

Plan Developed By (signature/title)_____ Date:_____/____/_____

Physician Signature:_____ Date:_____/____/_____

CARE PLAN REVIEW

DATE	REVIEWED/REVISED BY (signature/title)	COMMENTS

PART 1 – Clinical Record **PART 2 - Therapist**

PATIENT NAME – Last, First, Middle Initial	ID#