SIHO Physical Therapy
Treatment Plan for Certification

Patient Name: _____ Date: _____

Member ID# _____ Evaluation Date: _____

Facility: _____ Therapist: _____

Ordering Doctor: _____ Age: _____ Developmental Age: _____

Date of Injury/Trauma/Surgery: _____ # Visits Used To Date: _____

Background Information: (Include Diagnosis and ICD 9 Code)

Functional Limitations:

Short Term Goals (One Month):

Treatment Plan: If treatment involves casts, splints or assistive devices please indicate.

Frequency and Duration:

_____ _____

Therapist Signature Date

tjh/12/02