East Ocala - Advanced Physical Therapy of Central Florida

3845 SE Lake Weir Ave
Ocala, FL 34480-9153
Phone: (352)693-3378
Fax: (888)758-9645

Physical Therapy Initial Examination

Patient Name: dfgd dfg
Date of Birth: 03/20/2001
Referring Physician(s):
Visit No.: 1

Date of Initial Examination: 12/07/2017 11:19 AM
Injury/Onset/Change of Status Date: 11/15/2017 02:36 PM
Diagnosis:ICD-10: M00.061 : Staphylococcal arthritis, right knee C43.61 : Malignant melanoma of right upper limb, including shoulder

Subjective

Patient is a 16 years old male who presents with complaint of Pain, Swelling, Redness in the trh Onset was gradual beginning on 11/15/2017. Patient complains of impaired Walking, Crawling, Climbing, Sitting, Toileting, Standing.

Objective

Gait Ererr.

Special Tests Ererer.

Assessment

Patient presents with impaired Pain, Swelling, Redness all of which adversely affect patient ability to perform Walking, Crawling, Climbing, Sitting, Toileting, Standing patient will benefit from skilled physical therapy treatment 3 time(s) per week for 3 in order to address above - noted deficits and to return patient to prior level of function.prior level of function.

Plan

Patient will benefit from skilled physical therapy treatment 3x per week for 3 week(s) for: ADL Training, TENS Training.

Certification of Medical Necessity: It will be understood that the treatment plan mentioned above is certified medically necessary by the documenting therapist and referring physician mentioned in this report. Unless the physician indicates otherwise through written correspondence with our office, all further referrals will act as certification of medical necessity on the treatment plan indicated above.

Thank you for this referral. If you have questions regarding this plan of care, please contact me at (352)693-3378.

Sudeep Bhattacharjee
License #1447613690
Electronically Signed by Sudeep Bhattacharjee on 12/7/2017 6:51:44 PM

Please sign and return:
Fax#: (888)758-9645

I certify the need for these services furnished under this plan of treatment and while under my care.

- [x] I have no revisions to the plan of care.
- [ ] Reviewed the plan of care as follows:

_____

Physician Signature