

**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: sanjay yadav
Date of Birth: 11/11/1990
Referring Physician(s):
Visit No.: 1

Date of Initial Examination: 12/12/2017 12:06 PM
Injury/Onset/Change of Status Date: 12/12/2017 11:54 AM
Diagnosis: ICD-10: M00.069 : Staphylococcal arthritis,
unspecified knee

Subjective

Patient is a 27 years old male who presents with complaint of Pain, Balance Deficit, Weakness. onset was sudden beginning on 12/12/2017. Patient complains of impaired Crawling, Toileting.

Objective

Range of Motion impairment at 4% of normal in the left knee. Ghjhghgj
Standing Balance Yuuy.

Assessment

Patient presents with impaired Pain, Balance Deficit, Weakness all of which adversely affect patient ability to perform Crawling, Toileting patient will benefit from skilled physical therapy treatment 0 time(s) per week for 5 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 undefinedx per week for 5 week(s) for: ADL Training, Tissue Mobilization.

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.

A handwritten signature in blue ink, appearing to read 'Sudeep Bhattacharjee', is written over a horizontal line.

Sudeep Bhattacharjee
License #1447613690
*Electronically Signed by Sudeep Bhattacharjee
on 12/12/2017 4:24:22 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.

- ☒ I have no revisions to the plan of care.
☐ Reviewed the plan of care as follows:

Physician Signature