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: ytuytu yutyu
Date of Birth: 12/03/1990
Referring Physician(s):
Visit No.: 1

Date of Initial Examination: 12/07/2017 06:36 PM
Injury/Onset/Change of Status Date: 12/07/2017 05:38 PM
Diagnosis:ICD-10: M00.062 : Staphylococcal arthritis, left knee

Subjective

Patient is a 27 years old male who presents with complaint of Swelling, Balance Deficit. Onset was sudden beginning on 12/07/2017. Patient complains of impaired Crawling, Toileting, Getting out of bed.

Objective

Standing Balance Gh,lfut,futr.

Assessment

Patient presents with impaired Swelling, Balance Deficit all of which adversely affect patient ability to perform Crawling, Toileting, Getting out of bed patient will benefit from skilled physical therapy treatment 1 time(s) per week for 12 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 1x per week for 12 week(s) for: Therapeutic Activities, 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.

RAKESH KUMAR BAROI
License #1447613690
Electronically Signed by RAKESH KUMAR BAROI on 12/7/2017 6:52:14 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