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: Rahul Barman
Date of Birth: 12/23/1956
Referring Physician(s):
Visit No.: 1

Date of Initial Examination: 11/30/2017 03:49 AM
Injury/Onset/Change of Status Date: 11/29/2017 05:37 PM
Diagnosis:ICD-10: M00.069 : Staphylococcal arthritis, unspecified knee M00.161 : Pneumococcal arthritis, right knee M20.032 : Swan-neck deformity of left finger(s)

Subjective

Patient is a 60 years old male who presents with complaint of Swelling, Weakness, Numbness, Tingling in the jkhk Onset was sudden beginning on 11/29/2017. Patient complains of impaired Crawling, Toileting, Sit to stand transfers.

Objective

Range of Motion impairment at 64% of normal in the right knee. Nbjhjhkjhk

Range of Motion impairment at 64% of normal in the right knee. Nbjhjhkjhk

Palpation Nbvnbvmn.

Range of Motion impairment at 65% of normal in the finger. Bjnhgjhgjjh

Palpation Ghjhgjhgj.

Assessment

Patient presents with impaired Swelling, Weakness, Numbness, Tingling all of which adversely affect patient ability to perform Crawling, Toileting, Sit to stand transfers patient will benefit from skilled physical therapy treatment 3 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 3x per week for 5 week(s) for: Therapeutic Activities, Manual Therapy, 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.

Sudeep Bhattacharjee
License #1447613690
Electronically Signed by Sudeep Bhattacharjee on 11/30/2017 3:51:38 AM

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