

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

Date of Initial Examination: 11/29/2017 11:04 AM
Injury/Onset/Change of Status Date: 11/28/2017 03:06 PM
Diagnosis: ICD-10: L03.011: Cellulitis of right finger

Subjective

Patient is a 27 years old male who presents with complaint of Swelling in the hgjghj Onset was sudden beginning on 11/28/2017. Patient complains of impaired Crawling.

Objective

Range of Motion impairment at 545% of normal in the finger. 4545fhgfh

Assessment

Patient presents with impaired Swelling all of which adversely affect patient ability to perform Crawling patient will benefit from skilled physical therapy treatment 3 time(s) per week for 18 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 18 week(s) for: Therapeutic Activities.

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 'Sanu Monu', is written over a horizontal line.

License #
Electronically Signed by
on 11/29/2017 11:05:45 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.

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

Physician Signature
, MD