

**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 Bose  
**Date of Birth:** 11/22/2017  
**Referring Physician(s):**  
**Visit No.:** 1

**Date of Initial Examination:** 11/23/2017 05:00 PM  
**Injury/Onset/Change of Status Date:** 11/22/2017 05:12 PM  
**Diagnosis:** ICD-10: M00.062: Staphylococcal arthritis, left knee

**Subjective**

Patient is a 0 years old male who presents with complaint of Pain, Balance Deficit. Onset was sudden beginning on 11/22/2017. Patient complains of impaired Crawling, Climbing.

**Objective**

Range of Motion impairment at 12% of normal in the left knee. Yjgfjh

**Assessment**

Patient presents with impaired Pain, Balance Deficit all of which adversely affect patient ability to perform Crawling, Climbing patient will benefit from skilled physical therapy treatment 2 time(s) per week for 4 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 2x per week for 4 week(s) for: 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.

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

A handwritten signature in blue ink, appearing to be a stylized 'R' or similar character.

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:

License #  
Electronically Signed by  
on 11/28/2017 12:56:37 PM

\_\_\_\_\_  
Physician Signature  
, MD