**East Ocala - Advanced Physical Therapy of Central Florida**

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# Physical Therapy Initial Examination

**Patient Name:** dswe hhg
**Date of Birth:** 12/12/1990
**Referring Physician(s):**
**Visit No.**: 1

**Date of Initial Examination:** 11/29/2017 10:33 AM
**Injury/Onset/Change of Status Date:** 11/29/2017 10:06 AM
**Diagnosis:**ICD-10: M00.062: Staphylococcal arthritis, left knee

## Subjective

Patient is a 26 years old male who presents with complaint of Swelling, Weakness in the dfghgf Onset was sudden beginning on 11/29/2017. Patient complains of impaired Bathing.

## Objective

Standing Balance Fgyhgf.

Gait Fghgf.

## Assessment

Patient presents with impaired Swelling, Weakness all of which adversely affect patient ability to perform Bathing patient will benefit from skilled physical therapy treatment 3 time(s) per week for 9 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 9 week(s) for: Therapeutic Activities, Ultrasound.

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.

License #
*Electronically Signed by*
*on 11/29/2017 10:36:04 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.
- [ ] Revise the plan of care as follows:

Physician Signature
, MD