PHYSICAL THERAPY ROUTE SHEET

HOME HEALTH AGENCY:

PATIENT NAME:

MR#:

THERAPIST NAME:

VISIT CODE	DATE	START TIME	END TIME	TOTAL TIME	PATIENT SIGNATURE

SERVICE CODES:

* 1 EVAL
* 2 FOLLOW-UP VISIT
* 3 RE-CERTIFICATION
* 4 RESUMPTION OF CARE
* 5 DISCHARGE
* 6 OTHER

By signing this document, I agree that all of the above-mentioned visits have been performed and accurate.

THERAPIST SIGNATURE: _____