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| **OUTPATIENT PLANNING RECORD/REPORT** |

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| **Report Date:** |  |
| **Patient Name:** |  |
| **Patient/ contact number:** |  |
| **Patient File Number:** |  |
| **Funder name:** |  |
| **Membership number:** |  |
| **Outpatient Authorisation Number:** |  |
| **Diagnosis:** |  |
| **ICD 10 code/s:** |  |
| **Date of onset/incident:** |  |
| **Date of assessment:** |  |
| **Place of assessment:** |  |
| **Treating/ Referring Doctor:** |  |
| **Pre-incident level of functioning:** |  |
| **Current level of function:** |  |
| **Predicted level of functioning at discharge:** |  |
| **Practice Numbers:** |  |
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| **FIM Score** | | | | | | | | | | | | | | | | | | | | | |
| **Date** | Eating | Grooming | Bathing | Dressing - Upper | Dressing – Lower | Toileting | Bladder | Bowel | TRF Bed/Chair/WC | TRF Toilet | TRF Bath/Shower | Walk / WC | Stairs | **Motor Total /91** | Comprehension | Expression | Social interaction | Problem Solving | Memory | **Cognitive Total /35** | **Total /126** |
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| **FAM Scale** | | | | | | | | | | | | | | | |
| Date | Swallowing | Car Transfer | Community Mobility | **Motor Total /21** | Reading | Writing | Speech Intelligibility | Emotional Status | Adjustment to Limitations | Leisure Activities | Orientation | Concentration | Safety Awareness | **Cognitive/Psychosocial /63** | **Total /84** |
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| **Relevant Medical History** | | | | **Summary of personal and environmental context (equipment and home adaptations, family and patient education, barriers and resources)** | | | | |
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| **PT Summary of initial clinical presentation (relevant impairments, activity and participation)** | | | **OT Summary of initial clinical presentation (relevant impairments, activity and participation)** | | | **ST Summary of initial clinical presentation (relevant impairments, activity and participation)** | | |
|  | | |  | | |  | | |
| **Date of outpatient planning / goal setting discussion:** | **Goals for requested number of sessions for each profession:**  Must be adjusted according to authorised sessions and patient/ family goals | | | | | | **Treating Therapists:**  **PT:**  **OT:**  **ST:** | |
| **MONTHLY TREATMENT PLAN / GOALS** | | | | | | | | |
|  | **Management of Health Condition and Equipment needs** | **Training and Ongoing Care Management**  Including Therapy Specific Functional Goals | | | **24 Hour Programme and**  **Reintegration** | | | **Psychosocial Wellbeing** |
| **Current Month** | | | | | | | | |
| Date:  Remaining nr of sessions:  PT:  OT:  ST: |  |  | | |  | | |  |
| **Treatment Record** | | | | | | | | |
| Date:  Remaining nr of sessions:  PT:  OT:  ST: |  |  | | |  | | |  |