SAMPLE

PT ___ OT ___ ST _X_ THERAPEUTIC SERVICES PLAN OF CARE

1.Patient's Name and Address:	3. Start of Care Date:		4. Certification Period: FROM: TO:
	5. Provider's Name, Address and Telephone Number:		6. Provider Number:
2. Patient's Social Security Number:			8. Gender: M__ _ F__
7. Date of Birth:			
9. Diagnosis:		Date:	10. Precautions/ Safety Concerns:
11. Durable Medical Equipment:			12. Allergies:
13.Nutritional Requirements:			14. Medications: Dose-Frequency

15A. Functional Limitations:
_____ Speech impairment
_____ Swallowing impairment
_____ Bowel/Bladder
_____ Contracture
_____ Hearing
_____ Ambulation
_____ Legally Blind
_____ Other (Specify)

15B. Activities Permitted:
_____ Up as Tolerated
_____ Walker/ Cane // WC
_____ Weight Bearing status
_____ No Restrictions
_____ Other (Specify):

16. Mental Status:
_____ Oriented _____Comatose
_____ Forgetful _____ Depressed
_____Disoriented _____ Lethargic
_____Agitated
_____Other (Specify) _____

17. Prognosis:

Rehab Potential:

D/C Plans:

18.Orders for Discipline and Treatments: Up to eight hours per month from 4/5/06 to 7/5/06 and up to four hours per month from 7/5/06 to 4/4/07 with up to an additional four hours in 12/06 for an annual re-assessment.

ACTIONS	INTERVENTIONS	TIMEFRAMES
1. Joe will increase his sign vocabulary to 50 signs in order to communicate his wants and needs daily to his staff. 2. Joe will use a picture exchange communication system with minimal cuing at least 10 times per day to request items and convey information to staff. 3. When given the choice between two preferred community activities, Joe will independently choose an activity each day using his scheduling board. 4. Joe will have zero incidences of choking for six months.	1. Direct speech services for building sign language vocabulary. 2. SLP will work with support staff to develop staff instructions for use of the picture exchange system. 3. SLP will work with support staff to develop staff instructions for daily scheduling. 4. SLP will work with support staff to develop staff instructions for mealtime. 5. Training, competency checks, and monitoring of staff instructions will be completed. 6. Annual speech re-assessment.	1. 4/5/06 to 4/4/07 2. 4/5/06 to 4/4/07 3. 4/5/06 to 7/5/06 4. 4/5/06 to 7/5/06

STATUS/Annual Progress:

20. Physician's Name and Address:	21. Therapist's Signature and Date:
	Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal Funds maybe subject to fine, imprisonment, or civil penalty under applicable Federal Laws.
Physician's Signature and Date:	I certify / re-certify that this patient requires Speech Therapy. The patient is under my care, and I have authorized the services on this plan and will review the plan annually.

SAMPLE

PT ___ OT ___ ST _X_ THERAPEUTIC SERVICES PLAN OF CARE

1.Patient's Name and Address:	3. Start of Care Date:	4. Certification Period: FROM: TO:
	5. Provider's Name, Address and Telephone Number:	6. Provider Number:
2. Patient's Social Security Number:		8. Gender: M__ _ F__
7. Date of Birth:		