THERAPEUTIC SERVICES PLAN OF CARE
TEMPLATE ONLY

Services: _____OT _____PT _____SLH _____Nutrition _____Orientation and Mobility

Service Recipient's Name and Address::			SS#:
DOB:	Gender: _____M _____F	Date Referral Received:	ISP Effective Date:
Provider's Name, Address and Telephone #:		Provider Number:	

(DOH Requirements for OT, PT, SLH only – specify as needed) (RDs remove if not applicable)

Diagnosis: Prognosis: Equipment Required: Safety Measures: Nutritional Requirements:	Mental Status: Rehab Potential: Medications: Activities Permitted:	Current Treatment: Functional Limitations: Discharge Instructions: Other:

Current Status/Progress Noted:

(Recommendations must be reviewed by the COS and Planning Team. If necessary, the recommendations may need to be revised during the Planning Meeting. In order for the POC to be in agreement with the actions in the ISP, the POC may need to be updated prior to PCP signature)

GOALS	INTERVENTIONS	TIMEFRAMES
Recommended Amount, Frequency, and Duration: *Amount (# units/visits depending on discipline)* *Frequency (per week/month)* *Duration (# weeks/months)*		

Physician's Name and Address:		Therapist's Signature, Credentials, and Date:
Physician's Signature:	Date of Signature:	