

PHYSICAL THERAPY: **PROGRESS NOTE** **RE-CERTIFICATION** **DISCHARGE** YEAR: _____

PATIENT NAME: _____ HIC # _____ PRECAUTIONS/WBS: _____

MED A **MED B** **HMO** **OTHER** _____ DX: _____ SOC: _____

PROBLEM	LAST PERIOD'S STATUS	CURRENT STATUS	UPDATED STG
	End Date: _____	From: _____ To: _____	

Improvement noted: yes no: _____ Complaints Of: _____ none

PROGRESS NOTE AND RE-CERTIFICATION Summary of Pt Resp to Tx (focus on areas of improvement) _____

Justification to Continue Services (Indicate outstanding goals & complexities affecting progress): _____

RE-CERTIFICATION Reached Med B CAP
Re-certified or updated LTG: _____

DISCHARGE ONLY Re-certified or updated Plan of Care: _____ Re-cert Dates:
From: _____ To: _____

Reason for discharge (include pt response to tx & areas of improvement) _____
Discharge Location: _____

Discharge Recommendations (include discharge instructions, caregiver training and equipment): _____

FOR RE-CERT / DC ONLY _____ Discharge