

# SIHO Occupational Re-Certification Request

Patient Name: \_\_\_\_\_ Member ID# \_\_\_\_\_

Date: \_\_\_\_\_

Facility: \_\_\_\_\_ Therapist: \_\_\_\_\_

**Initial Deficiencies (only fill in relevant deficiencies, but be specific):**

1. ROM: \_\_\_\_\_ Strength: \_\_\_\_\_

2. Function (submit copy of functional measurement tool): \_\_\_\_\_

3. Other: \_\_\_\_\_

**Treatment to Date (list in probable order of importance):** \_\_\_\_\_

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ Home Exercise Program: Yes  No

Brief Description (HEP): \_\_\_\_\_

**Change to Date in Deficiencies (use same as above):** Has progress slowed: Yes  No

1. ROM: \_\_\_\_\_ 2. \_\_\_\_\_

3. Function (latest functional measurement): \_\_\_\_\_

**Goals (be specific, but write "none" if none set):**

Patient's \_\_\_\_\_

Practitioner's \_\_\_\_\_

Therapist's \_\_\_\_\_

**Patient Compliance (check box):** Excellent  Adequate  Poor

\_\_\_\_\_  
Therapist Signature Date Practitioner Signature Date