

PLEASE FAX TO 812-378-7054

NOTE: PLEASE ATTACH A COPY OF THE PRACTITIONER ORDER

SIHO Physical Therapy Re-Certification Request

Patient Name: _____	Member ID # _____	
Date: _____	Facility: _____	Therapist: _____
Diagnosis/ICD 9 Code: _____	Date of First Visit: _____	
Total Visits to Date: _____	Projected Visits to Complete: _____	

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

1. ROM _____ 4. 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. _____

Brief description (HEP): _____

Change to Date in Deficiencies (use same as above):

Has progress slowed?: Yes No

1. ROM: _____ 4. Analog Pain Scale: (1-10) _____
2. Strength: _____ 5. Other: _____
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

If poor, in what regards? _____

Therapist Signature Date

Practitioner Signature Date

js/0101