

SIHO Physical Therapy Treatment Plan for Certification

Patient Name: _____	Date: _____	
Member ID# _____	Evaluation Date: _____	
Facility: _____	Therapist: _____	
Ordering Doctor: _____	Age: _____	Developmental Age: _____
Date of Injury/Trauma/Surgery: _____	# Visits Used To Date: _____	

Background Information: (Include Diagnosis and ICD 9 Code)

Functional Limitations:

Short Term Goals (One Month):

Treatment Plan: If treatment involves casts, splints or assistive devices please indicate.

Frequency and Duration:

Therapist Signature

Date