

Physical Therapy Documentation Form



Fax this completed form to 855-662-7969.

Member name _____ Authorization number _____

Facility name _____ Facility contact _____

Facility phone _____

7=Independent 6=Modified independence 5=Supervision 4=Minimum assistance 3=Moderate assistance 2=Maximum assistance 1=Total assistance

Initial evaluation status	Date of update				
	Number of days requested				
	Bed mobility				
	Rolling				
	Bridging or scooting				
	Sit to supine				
	Supine to sit				
	Transfers				
	Sit to stand				
	Bed to chair				
	Gait				
	Weight bearing status				
	Distance				
	Assistance level with gait				
	Type assistive device				
	Stairs or curb				
	Wheelchair propulsion and management				
	Balance				
	Static sit				
	Dynamic sit				
	Static stand				
	Dynamic stand				
	Range of motion and strength				
	Lower extremity, right or left				
	Discharge plan				

Comments