PHYSICAL MEDICINE REHABILITATION PROGRESS REPORT

Date: _____ Provider's Name: (print legibly)_____ License Type and No.: _____
Phone: _____ Fax: _____ Address: _____

Patient: _____ Claim No.: _____
Case Manager: _____ Physician: _____

ICD – 10 Code(s): _____ ICF Code(s): _____
Date of Injury: _____ Date of Surgery: (if applicable) _____

Start of Care Date: _____
Number of Treatment Sessions Since Start of Care: _____ Number of Treatment Sessions Approved to Date: _____

TESTS AND MEASURES

Type of Test or Measure	Initial Examination Date: _____	Prior Progress Report Date: _____ (if applicable)	Current Progress Report Date: _____	Goal for Each Test or Measure
Self Report of Disability **(e.g., Oswestry, DASH)**				

Functional Limitations **(e.g., walking, driving, keyboard or lifting tolerance)**				

Physical Impairments **(e.g., joint ROM, muscle flexibility, strength, or endurance deficits)**				

Plan of Care/Intervention Strategies: _____
_____
_____
_____
_____

Rationale for Continued Treatment (if applicable): _____
_____

Number of Additional Treatments Requested over Next 30 Days (if applicable): _____

Estimated Duration of Care Needed to Achieve Goals (if applicable): _____

Recommendation:

- ☐ Continue Plan of Care/Intervention Strategies As Noted Above.
- ☐ Discharge from Care – Goals Met.
- ☐ Discharge from Care – Goals Not Met. Rationale: _____
  Recommendation: (if any) _____

Date of Next Re-Evaluation and Progress Report: _____

Signature of Provider: _____ Date: _____

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