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Of Treatment WorkSheetPhysical Therapy Plan Of
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Patient's Last Name First Name Enter Patient's First
Name MI HICN Enter SS/HICN Provider Name LifeCare
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Below ** SOC Date = Date Of Evaluation Primary Di
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Occupational Therapy Plan Of Treatment WorkSheetOT
Worksheet Page 2 Of 2 Revised 03/2010 Rehabilitation
History No Prior Therapy (PT, OT, SLP) Appears To
Have Been Provided In The Past 12 Months Or The
Patient Has Received ___ PT ___ OT ___ SLP In The Last
12 Months For The ___ Current Or A ___ Previous
Condition Describe: _Provide Details Of Prior Therapy
And Diagnosis If Known. 5th, 2024Occupational
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Heart Failure (chf), Unspecified, Excludes: Fluid

Overload Nos (276.6) 7/14/2013 Med 486. Pneumonia,

Organism Unspecified 7/14/2013 Med 786.09 Other

Dyspnea And Respiratory Abnormalities 7/14/2013 Med

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You Quickly Determine The Suggested Meal Plan For

You, And Will Match Your Individual Needs For Protein

And Calories. Based On Your Current Height And

Weight, Determine Whether You Step 1. Should Follow

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