Physical Therapy Plan of Care (POC)

Patient information
Name:
Date of birth:
Gender:
Contact information:
Evaluation date:
Diagnosis
Primary diagnosis:
Secondary diagnosis (if applicable):
Clinical presentation:
Goals/outcomes
Short-term goals:
Long-term goals:
Plan of care
Type of therapy:
Amount of therapy:
Duration of therapy:
Frequency of therapy:

Interventions
Progress monitoring
Re-evaluation schedule:
Outcome measures:
Discharge plan
Patient consent
By signing below, I confirm that I understand and agree to the outlined plan of care.
Patient name and signature:
Date:
Healthcare provider information
Name:
License ID number:
Contact information:
Signature:
Date: