

Physical Therapy Care Plan Template

Date: _____ **Student:** _____ **DOB:** _____ **School:** _____

Student's Physician: _____ **Physician NPI:** _____ **Date of Medical Referral:** _____

Student Diagnosis (ICD10): _____ **Service Level:** _____

This student is currently eligible for physical therapy services as indicated on his/her _____.

Date to begin: _____ **Duration of Plan:** _____

Goals/Objectives:

Motor Ability	Within Functional Limits	Deficient	Not Tested
1. Upper extremities			
a. Range of motion			
b. Muscle tone			
c. Muscle strength			
2. Lower extremities			
a. Range of motion			
b. Muscle tone			
c. Muscle strength			
3. Head control			
4. Trunk control			
5. Posture			
6. Sitting balance			
7. Standing balance			
8. Ambulation/ Mobility			
9. Transfers			
10. Classroom, Cafeteria, Bathroom, and Campus Management			
11. Bus, Playground, Terrain Management			

Possible Interventions: (CPT codes)

Skilled Intervention (Individual Therapy)

- Posture/Positioning
- Campus Mobility
- Wheelchair Mobility
- Ambulation/ Gait training
- Playground Management
- Balance
- Supported standing
- Negotiating stairs
- Orthosis (use/management)

Consult/Training: (see plan in student's folder)

- Classroom Strategies/ Team Consultation
- Transportation Plan
 - Evacuation Plan
- Environmental Modification/Adaptation
- Adaptive Equipment (mechanical lifts, adaptive seating, walkers, etc.)
- Staff Training (transfers, equipment, etc.)

Plan for Exit from Services: _____

The team will consider data for the student to be exited or plan of care will be modified based on student need. Students who no longer require direct PT services due to reasons indicated above may continue to require ongoing staff training to ensure student's safe access to their educational environment including but not limited to transfer training, toileting considerations, adaptive equipment, supervision on playground equipment etc.

Physical Therapist Signature/NPI number

Date

Update by: _____

Date: _____