# MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

| REQUIRING DOCUMENT *(Title and Number)* | | ISSUANCE DATE |
|---|---|---|
| INPATIENT DISCHARGE PLANNING TEAM | NAVHOSPPNCLAINST 6320.62J | 11 Feb 2013 |

LOCAL FORM TITLE *(Optional)*
OUTPATIENT PHYSICAL THERAPY ORDERS

Date of Discharge: _____ Receiving Agency: _____

Contact: _____ Phone: _____

**PATIENT INFORMATION:**

Name: _____ DOB: _____

Address: _____

Phone: _____

Family Contact: _____

**DIAGNOSES:**

1. _____
2. _____
3. _____
4. _____
5. _____

**PHYSICAL THERAPY:**

☐ ROM ☐ Ambulation ☐ Transfers ☐ Gait ☐ Strengthening ☐ Total Knee Protocol ☐ Total Hip Protocol

☐ Other: _____

_____

Frequency: _____ Duration: _____

CALL PHYSICIAN FOR: _____

**ATTENDING PHYSICIAN INFORMATION (PLEASE PRINT):**

Name: _____ Phone: _____ Beeper: _____

After Hrs Contact: _____ Phone: _____ Beeper: _____

PCM: _____ Phone: _____ Beeper: _____

| PRACTITIONER'S NAME | NPI# | PRACTITIONER'S SIGNATURE | DATE |
|---|---|---|---|
| | | | |

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*

| HOSPITAL OR MEDICAL FACILITY | STATUS |
|---|---|
| DEPARTMENT / SERVICE | RECORDS MAINTAINED AT |
| SPONSOR'S NAME | SSN |
| RELATIONSHIP TO SPONSOR | |