Demo Physical Therapy
123 Test St, Suite 3
Demo, AZ 85024-1144
Phone: (602)555-4879
Fax: (602)555-4880
www.google.com

Physical Therapy Re-Examination

GENESIS Rehab Services

Patient Name: "Little", Corky
Date of Birth: 02/04/2002
Referring Physician(s): Blackwell, Patricia CRNP
Visit No.: 6

Date of Re-Examination: 03/27/2012
Injury/Onset Date/Change of Status Date: 03/27/2012
Diagnosis: 726.32: Lateral epicondylitis
Treatment Diagnosis: 726.32: Lateral epicondylitis

Subjective

Informant Providing History: Mother
Treatment Side: N/A
History of Falls: No
Pain Scale: Worst: Best: Current:

Objective

Range of Motion

Shoulder AROM	Right	Left
Flexion	WNL	WNL
Scaption	WNL	WNL
Abduction	WNL	WNL
Extension	WNL	WNL
ER in Neutral Position	WNL	WNL
IR in Neutral Position	WNL	WNL
Horizontal Abduction	WNL	WNL
Horizontal Adduction	WNL	WNL

Shoulder PROM	Right	Left
Flexion	WNL	WNL
Scaption	WNL	WNL
Abduction	WNL	WNL
Extension	WNL	WNL
ER in Neutral Position	WNL	WNL
IR in Neutral Position	WNL	WNL
ER in Scapular Plane	WNL	WNL
IR in Scapular Plane	WNL	WNL
ER in 90 Degrees Abduction	WNL	WNL
IR in 90 Degrees Abduction	WNL	WNL
IR in Sleeper Stretch position	WNL	WNL
Horizontal Abduction	WNL	WNL
Horizontal Adduction	WNL	WNL

Strength

Selective Tissue Tension Lower

Hip

	Right	Left
Hip Flexion	Strong and Painless	Strong and Painless
Hip Adduction	Strong and Painless	Strong and Painless
Hip Abduction	Strong and Painless	Strong and Painless
Hip Extension	Strong and Painless	Strong and Painless
Hip Internal Rotation	Strong and Painless	Strong and Painless
Hip External Rotation	Strong and Painless	Strong and Painless

Assessment

Rehab Potential: Good
Contraindications to Therapy: None
Patient Problems:

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- patie

Short Term Goals:
1: (1 Visit) | 0% | patien |

Plan

Frequency: 1 time visit only
Duration: N/A
Plan: Begin Plan as Outlined
Treatment to be provided:

Certification of Medical Necessity: It will be understood that the treatment plan mentioned above is certified medically necessary by the documenting therapist and referring physician mentioned in this report. Unless the physician indicates otherwise through written correspondence with our office, all further referrals will act as certification of medical necessity on the treatment plan indicated above.

Thank you for this referral. If you have questions regarding this plan of care, please contact me at (602)555-4879.

Scottie Pippen
License #4564
Completed by Scottie Pippen on June 20, 2012 at 12:13 pm

Please sign and return: Fax#: (602)555-4880

I certify the need for these services furnished under this plan of treatment and while under my care.

__I have no revisions to the plan of care.
__Revise the plan of care as follows_____
_____

Physician Signature_____
P. Blackwell, CRNP

Date:_____