FOLLOW-UP PLAN OF CARE

PATIENT NAME :_____DATE _____ ☐ VISIT ☐ PHONE
ADDRESS:_____DOB: __/__/_____SOC-SEC-#_____
TELEPHONE: (__)_____ ALT. CONTACT: _____ ALT. TEL: (__)_____
DIAGNOSIS:_____ PHYSICIAN:_____ (__)_____

~~~~~~ALL ITEMS REVIEWED AND UNCHANGED √ BOX ONLY IF CHANGED & NOTE CHANGE~~~~~~~

☐ SAFETY AND ENVIRONMENT _____
☐ OTHER HOME CARE SERVICES _____
☐ EQUIPMENT USE, OPERATION _____
☐ CLEANING & MAINTENANCE OF DEVICE _____
☐ SERVICES & COMPLAINTS _____

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PATIENT STATUS~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

	IMPROVED	SAME	WORSE
PAIN,	☐	☐	☐
STIFFNESS,	☐	☐	☐
SWELLING	☐	☐	☐
MOBILITY	☐	☐	☐

SOURCE OF INFORMATION:_____

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~EQUIPMENT SETTINGS~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

DEVICE:_____ **SERIAL/BATCH/LOT#**_____

	INCREASE	DECREASE	SAME
FREQ. OF USE: _____	☐	☐	☐
DURATION: _____	☐	☐	☐
SETTINGS: _____	☐	☐	☐
_____			

LENGTH OF TIME ON EQUIPMENT: _____

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ADDITIONAL NOTES~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

NEED	GOAL	RESULTS

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~FOLLOW-UP/DISCHARGE~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

FO LLOW-UP VISIT RECOMMENDED ☐ _____ **FOLLOW-UP BY PHONE & AS NEEDED** ☐

NEXT DR. VISIT:_____ **EQUIP TO BE P/U:** _____

I HAVE READ, RECEIVED AND BEEN INSTRUCTED IN DETAIL ON THE ITEMS CHECKED ABOVE.

If patient is unable to sign, complete the following:

Patient/Auth Rep Signature:_____Name of authorized person (print)_____

EmployeeSignature_____Relationship_____Why Pt Cannot Sign:_____