

**PHYSICAL MEDICINE AND REHABILITATION NOTE
CENTER FOR ASSISTIVE TECHNOLOGY**

PATIENT NAME is a(n) AGE year old {MAN/WOMAN} with *** who presents with a chief complaint of a need for {CHIEF COMPLAINT}.

PATIENT NAME currently uses {MOBILITY MEANS} for mobility. Issues have included: {ISSUES}.

The client {ALTERNATIVES}.

History also obtained from {RELATIONSHIP}.

PAST MEDICAL/SURGICAL HISTORY:

OTHER MEDICAL HISTORY IN E-RECORD PULLED IN AUTOMATICALLY
ACTIVE PROBLEM LIST PULLED IN AUTOMATICALLY

FUNCTIONAL HISTORY:

Mobility: {MOBILITY}.

Self Care: The client needs assistance with the following ADL's that could be performed at a more independent level if mobility status were improved: {ADLS}.

Braces: {BRACES}

Assistive Devices: {ASSISTIVE DEVICES}.

MEDICATIONS:

Current outpatient prescriptions pulled in automatically

SOCIAL HISTORY:

Home: Patient lives {HOME}.

FAMILY HISTORY:

Family history pulled in automatically

REVIEW OF SYSTEMS:

Denies: {DENIES}
 Endorses: {ENDORSES}
 Pain: {PAIN}
 Skin Issues: {SKIN}
 Bowel/Bladder: {BLADDER}
 Vision: {VISION}
 Shoulders: {SHOULDER}
 Mood and Sleep: {PSYCH}
 Weight: {WEIGHT CHANGE}
 All other systems are negative.

PHYSICAL EXAMINATION:

General: {GENERAL}
 Heart: {HEART}
 Lungs: {LUNGS BRIEF EXAM}
 Abdomen: {ABDOMEN}
 Musculoskeletal: {MUSCULOSKELETAL}
 Spinal Alignment: {BACK EXAM}
 Strength:

	Right	Left
Biceps (C5)	{MUSCLE STRENGTH}	{MUSCLE STRENGTH}
Wrist Extension (C6)	{MUSCLE STRENGTH}	{MUSCLE STRENGTH}
Triceps (C7)	{MUSCLE STRENGTH}	{MUSCLE STRENGTH}
Finger Flexors (C8)	{MUSCLE STRENGTH}	{MUSCLE STRENGTH}
Intinsics (T1)	{MUSCLE STRENGTH}	{MUSCLE STRENGTH}
Hip Flexors (L2)	{MUSCLE STRENGTH}	{MUSCLE STRENGTH}
Quads (L3)	{MUSCLE STRENGTH}	{MUSCLE STRENGTH}
Ankle DF (L4)	{MUSCLE STRENGTH}	{MUSCLE STRENGTH}
Hip Abductors (L5)	{MUSCLE STRENGTH}	{MUSCLE STRENGTH}

Other Muscle Groups: {OTHER MUSCLES}
 Sensation: {SENSORY EXAM}
 Reflexes: {REFLEXES}
 Tone: {TONE}
 Gait: {GAIT}.
 Other Neuro: {OTHER NEURO EXAM}
 Skin and Extremities: {SKIN}

ASSESSMENT:

This is a(n) AGE year old who is in need of a new {DEVICE}. The client {JUSTIFICATION}. These reasons serve as medical justification for this device.

PLAN:

I will work along with an OT and/or PT to complete a evaluation functional mobility assessment. Specifications will be determined based on this assessment. A home assessment will then be performed by the rehabilitation technology supplier if necessary.

Length of need is likely {LENGTH OF NEED}.

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