Laurel Health
Physiotherapy & Wellness
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PLAN OF CARE
(Patient Informed Consent)

Name:_____Date:_____

Primary Problem:_____

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

How much is this affecting you? Mild Moderate Severe

PHYSICAL THERAPY FINDINGS

Problems / Limitations or Goals

1._____

2._____

3._____

Plan of Care / Treatment

1._____

2._____

3._____

Frequency / Duration

_____Times per week for weeks

_____Other

Home

Instructions

_____Heat / Ice (__minutes___times per day)

_____Exercises as instructed

I agree to the above treatment plan and give my informed consent to begin treatment. If the plan changes as treatment proceeds, the new treatment, risks and reasons will be explained. I have the right to ask questions and I have the responsibility to inform my therapist of any changes in my condition or concers I have. I have the right to withdraw consent to the plan at any time.

Patient Signature:_____Date:_____

Therapist Signature:_____Date:_____