PLAN OF CARE

Patient's Name _____DOB_____

Medicaid #_____Medical Doctor _____

Diagnosis: _____ Diagnosis Code: _____

Effective Dates:_____**Frequency/Duration**:_____

Estimated Duration: _____ R**ehabilitation/Recovery Potential**: ☐ Good ☐ Fair ☐ Poor

Location of Service: ☐ Therapy Rm ☐ Reg Ed/SPED Classroom **Service Provider**: _____

Current Level of Performance: _____

_____

Medication: _____

☐ **Initial** ☐ **Annual Review**

Previous Goals and Objectives (documented progress): _____

_____

_____

Current Goals and Objectives: _____

_____

_____

Types of Modalities and Procedures: _____

_____

_____

X **Referring Physician Signature** _____ **Date:** _____

Provider Signature _____ **Date:** _____

PLEASE RETURN COMPLETED FORM TO: ***Brantley County Board of Education***

SPED DEPARTMENT / WENDY LEE

272 SCHOOL CIRCLE

NAHUNTA, GA 31553

FAX: 912-462-6119

FORM Q2