McLaren Flint
Flint, Michigan
OUTPATIENT REHABILITATION CERTIFICATION-RECERTIFICATION
PLAN OF CARE/PROGRESS REPORT

☐ Pulmonary Therapy
☐ Occupational Therapy
☐ Physical Therapy
☐ Speech Therapy

Diagnosis: _____ Date of Birth: _____

☐ CERTIFICATION
Plan of Care

1. I certify that I have examined the patient and the above therapy is necessary for the following reasons:

_____
_____
_____

☐ Blue Cross
30 Day
Plan of Care

Plan of Care: _____
_____
_____
_____

From: _____ Long Term Goal: _____
_____

To: _____
_____
_____

_____ _____
Therapist Signature/Date Phone Number

2. I estimate that the period of therapy will be _____ per week for a period of _____weeks.

_____ _____
(Attending Physician) (Date)

1st
☐ RECERTIFICATION
Plan of Care

1. I certify I have examined the patient and that the above therapy is necessary for the following reasons:

_____
_____
_____

☐ Blue Cross
30 Day
Plan of Care

Plan of Care: _____
_____
_____
_____

From: _____ Long Term Goal: _____
_____

To: _____ _____
_____

_____ _____
Therapist Signature/Date Phone Number

2. I estimate that the period of therapy will be _____ per week for a period of ____weeks.

_____ _____
(Attending Physician) (Date)

OUTPATIENT REHABILITATION
CERTIFICATION - RECERTIFICATION
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PT.

MR.#/RM.

DR.

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PLAN OF CARE/PROGRESS REPORT

2nd
☐ RECERTIFICATION
Plan of Care

☐ Blue Cross
30 Day
Plan of Care

From: _____

To: _____

1. I certify that I have examined the patient and the above therapy is necessary for the following reasons:

_____
_____
_____

Plan of Care: _____
_____
_____
_____

Long Term Goal: _____
_____
_____
_____

_____ _____
Therapist Signature/Date Phone Number

2. I estimate that the period of therapy will be _____ per week for a period of _____weeks.

_____ _____
(Attending Physician) (Date)

3rd
☐ RECERTIFICATION
Plan of Care

☐ Blue Cross
30 Day
Plan of Care

From: _____

To: _____

1. I certify that I have examined the patient and the above therapy is necessary for the following reasons:

_____
_____
_____

Plan of Care: _____
_____
_____
_____

Long Term Goal: _____
_____
_____
_____

_____ _____
Therapist Signature/Date Phone Number

2. I estimate that the period of therapy will be _____ per week for a period of ____weeks.

_____ _____
(Attending Physician) (Date)

PT.

MR.#/RM.

DR.