# Total Health & Wellness

RESTORE | RECOVER | RENEW

## Plan of Care

Date of Service:_____

Patient Name:_____ Date of Birth:_____

Service Representative:_____ Ht._____ Wt._____

Ordering Physician:_____Phone Number:_____

Item Number:_____Quantity:_____

Item Description: _____LOT: _____

Diagnosis:_____ Description:_____

Symptoms:_____

Previous Treatment Methods:_____

Previous Treatment Results: _____recovered/healed _____partial improvement _____ no change _____worse

Limitations: ____strength _____ROM _____cognitive impairment _____body shape/size

Length of Need:_____

Setting/Strength:_____

Frequency of Use:_____

Expected Outcomes: _____reduce pain _____increase mobility _____prevent disease _____restore function

Follow up With: _____Service Representative _____Physician _____Physical Therapy _____None needed

Notes:_____

_____

Client has been instructed on use, donning/doffing, maintenance, cleaning, and warranty of the product(s) dispensed.

_____ _____

Client Signature Date