

**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
OUTPATIENT REHABILITATION UTILIZATION REVIEW**

Recipient: _____ Date of Birth: _____ Age: _____
 VMAP#: _____ Diagnosis: _____
 Provider: _____ Provider #: _____
 Dates Under Review: _____ UR Date: _____
 _____ Reviewer: _____

| Discipline | Physical Therapy | | | Occupational Therapy | | | Speech Therapy | | |
|---|-------------------------|--|--|-----------------------------|--|--|-----------------------|--|--|
| Physician Order for Eval | | | | | | | | | |
| Admission & D/C Dates | | | | | | | | | |
| Assessment/Evaluation | | | | | | | | | |
| Diagnosis/History | | | | | | | | | |
| Current Fx Status | | | | | | | | | |
| Therapist Signature/Title/Date | | | | | | | | | |
| Initial Plan of care (POC)/acute/non-acute | | | | | | | | | |
| Implementation Date | | | | | | | | | |
| Modalities/Procedures | | | | | | | | | |
| Frequency/Duration | | | | | | | | | |
| Goals Id'd - STG/LTG | | | | | | | | | |
| Measurable Goals - STG and LTG | | | | | | | | | |
| Achv. Dates -STG/LTG | | | | | | | | | |
| Discharge Plan | | | | | | | | | |
| Therapist Signature/Title/Date | | | | | | | | | |
| Physician Signature/Date/21 days | | | | | | | | | |

Physical Therapy POC reviews (q60 day or annual) with required POC components:

Dates of Plans of Care: _____
 Modalities/Procedures: _____
 Frequency/Duration: _____
 Goals Identified-STG and LTG: _____
 Measurable Goals-STG and LTG: _____
 Achievement Dates-STG and LTG: _____
 Discharge Plan: _____
 Therapist-Signature/Title/Date: _____
 Physician-Signature/Date/21 days: _____

Occupational Therapy POC reviews (q60 day or annual) with required POC components:

Dates of Plans of Care: _____
 Modalities/Procedures: _____
 Frequency/Duration: _____
 Goals Identified-STG and LTG: _____
 Measurable Goals-STG and LTG: _____
 Achievement Dates-STG and LTG: _____
 Discharge Plan: _____
 Therapist-Signature/Title/Date: _____
 Physician-Signature/Date/21 days: _____

