McLaren Flint
FLINT, MICHIGAN

PHYSICAL THERAPY TREATMENT FLOW SHEET

Evaluation Completed:___/___/___

Diagnosis: _____ **Precautions:** _____

Treatment	Date:___/___/___	Date:___/___/___	Date:___/___/___	Date:___/___/___	Date:___/___/___	Date:___/___/___
Pt. Education Provided						
Patient Understood Tx						
Patient's Initials						

Therapist Signature: _____ Patient Signature: _____

Key: **HEP** = Home Exercise Program
√ = Same as previous date

Therapist Signature: _____

Therapist Signature: _____

PT.

MR.#/RM.

PHYSICAL THERAPY TREATMENT FLOW SHEET

460

McLaren Flint
FLINT, MICHIGAN

PHYSICAL THERAPY TREATMENT FLOW SHEET

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Diagnosis: _____ **Precautions:** _____

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