**To the attention of:**

|  |  |
| --- | --- |
| Address |       |
| Telephone number |       |

**Regarding:**

|  |  |
| --- | --- |
| PHN |       |
| Date of Birth |       |
| Address |       |
| Telephone |       |

|  |  |
| --- | --- |
| Date |       |

One of your patients recently came for an appointment at my clinic with me. Find below a brief summary report and treatment plan as a result of that meeting for your records.

**Case Management Treatment Plan**

**Case Details:**

|  |  |
| --- | --- |
| Date of First Visit |       |
| Specific Nature of Dysfunction |       |
| Primary Area(s) of Involvement |       |
| Secondary Area(s) of Involvement |       |
| Contraindications/Precautions |       |

**ADL Limitations / Assessment Findings:**

|  |
| --- |
|       |

**Type(s) of Care:**

|  |  |
| --- | --- |
| [ ]  Corrective |       |
| [ ]  Rehabilitative |       |
| [ ]  Palliative |       |
| [ ]  Preventative |       |
| [ ]  Stress Management |       |
| [ ]  Other |       |

**Other Details / Treatment Objectives / Remedial Exercise Plan:**

|  |
| --- |
|       |

**Ideal Treatment Frequency (Reassessment Dates Included):**

|  |  |
| --- | --- |
| Post Initial Assessment Treatment Frequency |       |
| Date of Second Assessment |       |
| Post Second Assessment Treatment Frequency |       |
| Date of Third Assessment |       |
| Post Third Assessment Treatment Frequency |       |

Please do not hesitate to get in touch if you have any questions or concerns.

Sincerely,