**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,