Short-Term Rehabilitation Therapy Extension Request Form

PATIENT INFORMATION:

Member name:	Diagnosis/ICD Code:
Referring provider:	Total treatments:
Initial evaluation date:	Last date patient seen:

REQUESTED SERVICE:

Physical therapy ☐ **Occupational therapy** ☐ **Speech therapy** ☐

Number of Visits requested in this 4-week period:

CLINICAL UPDATE

	Initial evaluation	**Current status**
Range of Motion		
Strength		
Education		

Functional Goals	**Initial evaluation**	**Current status**
Short term #1		
Short term #2		
Short term #3		
Long term #1		
Long term #2		
Long term #3		

Kaiser Internal Use Only