Progress Note

Patient name: _____ Clinic Name
MRN: _____ Clinic Address
DOB: _____ Clinic Phone Number

Referring provider: _____
Address/Fax: _____
Provider type: internal/external

Primary diagnosis: _____
Treatment diagnosis: _____

Onset date: _____
SOC date: _____ Number of Visits: _____ Cancellations/No Show: _____

Outcome measure:
_____
_____
_____

Goals:
_____
_____
_____

Functional Assessment:
_____
_____
_____

Plan:
_____
_____
_____

Discharge date: _____ Continue Treatments needed: _____ / _____ times per week for ____weeks

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Athletic Trainer Signature Date

Plan of Care Authorization/Signature MD Date
Please Sign and Fax to (***)***-****