# REPORT OF CLIENT CARE

*Indicate by ticking appropriate box*

❒ Community Physiotherapy ❒ Community Occupational Therapy

| CLIENT'S NAME | CLIENT NUMBER |
|---|---|
| ADDRESS | |

LOCAL STAMP

PHYSICIAN (S)

| ADMITTED TO PROGRAM | DISCHARGED FROM PROGRAM | TOTAL NUMBER OF VISITS |
|---|---|---|
| | | |

DIAGNOSIS

| OPERATION | DATE OF OPERATION |
|---|---|
| | |

CLIENT CARE ( PROBLEM / INTERVENTION / CURRENT OR FINAL OUTCOME)

COPY TO: ❒ PHYSICIAN ❒ HOME CARE NURSE ❒ LONG TERM CARE ❒ OTHER:

| DATE | NAME *( please print )* | SIGNATURE |
|---|---|---|
| | | |