

# ANODYNE® THERAPY PLAN OF CARE

## Patient Information

Patient Name _____	Telephone Number _____
Permanent Address _____	Date of Birth _____
City / State / Zip _____	Sex _____

## Patient Diagnosis

ICD-9 Code	Condition	ICD-9 Code	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Duration of this condition:** \_\_\_\_\_ months

**Please check the prior therapeutic interventions that have been tried and failed to produce relief:**

- Anticonvulsants  
 Anti-depressants  
 Narcotics  
 Supplements (i.e. B<sub>12</sub>, Folate, Magnesium, etc.)  
 Other \_\_\_\_\_

## Patient Care Goals

*Note specific, quantifiable changes you expect to achieve in each area*

- Reduce pain (Pain Scale, Reduction in Meds, QOL, etc.) \_\_\_\_\_
  - Improve circulation (Monofilament, etc.) \_\_\_\_\_
  - Improve gait (Tinetti Score, Timed Get up and Go, etc.) \_\_\_\_\_
  - Improve balance (Berg, Romberg, Tinetti, etc.) \_\_\_\_\_
  - Improve range of motion in \_\_ Hip flexors by \_\_\_ degrees; \_\_ Ankles by \_\_\_ degrees; \_\_\_\_\_ by \_\_\_ degrees
  - Improve proprioception \_\_\_\_\_
  - ADLs/Other Goals \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Patient Care Plan

Treatment	Frequency	Minutes per Session	Total Sessions
<input type="checkbox"/> <b>Patient Gait/Balance Assessment</b> (97001)		N/A	
<input type="checkbox"/> <b>Anodyne Therapy</b> (97026)		_____ Mins. _____ Bars (One unit per session)	
<input type="checkbox"/> <b>Therapeutic Exercise</b> (97110) Strengthening, ROM, Flexibility		_____ Mins (15 mins per unit billed)	
<input type="checkbox"/> <b>Neuromuscular Reeducation</b> (97112) Movement, Balance, Proprioception		_____ Mins (15 mins per unit billed)	
<input type="checkbox"/> <b>Gait Training</b> (97116)		_____ Mins (15 mins per unit billed)	
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			

# Anodyne® Therapy Progress Notes

Patient Name \_\_\_\_\_

Anodyne Treatment Date:	
Pre Treatment Assessment <input type="checkbox"/> Follow-up Assessment <input type="checkbox"/>	Treatment Session Number _____
Treatment Session Time (Minutes):	Bar Setting _____

## Patient Assessment: Evidence of Poor Circulation

**Directions** - Note + or - in each of the circled areas showing ability (+) or inability (-) to sense a 5.07 monofilament, or note specific level of quantitative monofilament detected before beginning and after completion of therapy, or attach other evidence of increased circulation.

**PAIN**

**L Foot** 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 (circle one)

**R Foot** 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 (circle one)

**Hands** 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 (circle one)

**Other** 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 (circle one)

Sleeping Disruption/Pain at Night: \_\_\_\_\_ (x per wk)

## Patient Assessment: Medication

Current Pain Medications (Dose, Frequency): \_\_\_\_\_

Amount of Pain Medications: (Circle One)      Reduced      Increased      No Change

Current Sleeping Medications (Dose, Frequency): \_\_\_\_\_

Amount of Sleeping Medications: (Circle One)      Reduced      Increased      No Change

## Patient Assessment: Range of Motion, Proprioception, Gait, Balance, ADLs

Range of Motion: Ankle \_\_\_\_\_ Hip Flexors \_\_\_\_\_ Other \_\_\_\_\_

Proprioception:  Normal     Impaired     Absent

Improvements in:  Gait Score: \_\_\_\_\_     Balance Score: \_\_\_\_\_

### ADL's/OTHER OBSERVATIONS/PATIENT COMMENTS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Staff Signature** \_\_\_\_\_ **Date** \_\_\_\_\_