

**INSTRUCTIONS  
DHS 1147c**

**PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT),  
AND SPEECH THERAPY (ST) REPORT**

*Name, Birthdate, Date: Self-explanatory*

***Restorative Therapy (ies) being considered:***

Therapy is “restorative” when it is medically needed and there is a significant likelihood that the therapy will restore or improve function(s) and improve the person’s ability to perform activities of daily living (ADL). If more than one therapy is being requested and the goals, anticipated period of time therapy is needed, effective dates of therapy, etc. vary significantly, an 1147c form for each therapy should be sent.

***Primary diagnosis or medical condition for which the therapy (ies) is/are to be provided:***

State the primary diagnosis or medical condition for which the therapy (ies) are indicated. Examples: fracture of left hip; below knee amputation, etc.

***List applicable secondary diagnosis (s3es):***

List diagnosis (ses)/medical condition(s) which clarify the primary diagnosis or contribute to the understanding of the patient’s rehabilitative needs. Examples: for fracture of left hip; applicable secondary diagnoses can be osteoporosis or stress fractures.

***List the 3 main goals of therapy:***

Clearly list no more than the 3 most important, realistically achievable short-term rehabilitative goals. If more than one therapy is being requested, at least one goal should be reported for each therapy being sought.

***Anticipated period of time therapy is to be provided: (Self-explanatory)***

***Check ALL that apply: (Self-explanatory)***

***Additional justification for restorative therapy:***

Additional clinical information should be provided if the therapist does not feel that the answers given above clearly justify a person’s need for restorative PT, OT, or ST.

***Recommended effective date of restorative therapy:***

Medicaid will provide that restorative therapy the effective dates. For patients covered by both Medicare and Medicaid, if restorative therapy is covered under Medicare, this form is not needed unless therapy beyond the period covered by Medicare is being requested.

***Print Name and Title, Signature, Date.***

The form should be completed and signed by a therapist (PT, OT, ST). The Date is the signature date.