

Baker Orthotics & Prosthetics
Patient Goals

Patient Name: _____ Date: _____

Prescription: _____

Clinician: _____

Please list your goals:

Short Term Goals (function within home, walking, etc.)

1. _____

2. _____

3. _____

Long Term Goals (community mobility, eliminate use of assistive device, return to work, etc.)

1. _____

2. _____

3. _____

The goals provided above have been discussed between myself and the clinician.

Signature: _____ Date: _____

Name of person signing (Please print): _____

Relationship to patient: _____

Clinician signature

Date

Baker Orthotics & Prosthetics
Patient Goals Follow Up

Patient Name: _____ Today's Date: _____

Prescription: _____

Clinician: _____

Date of Initial Visit: _____ Date of Delivery: _____

Based on the goals you provided (see page attached), please tell if these goals were met to your satisfaction. If not, please explain.

Short Term Goals:

1. _____

2. _____

3. _____

Long Term Goals:

1. _____

2. _____

3. _____

I have discussed this review of goals with the clinician.

Signature: _____ Date: _____

Name of person signing (Please
print): _____

Relationship to patient: _____

Clinician signature

Date

