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1. General Information

Our vision is to create a unique and caring environment for the treatment of uninsured and underserved patients to fulfill a current lack of pro-bono physical therapy services in the Madison area by utilizing UW-Madison DPT student services with faculty oversight. We envision a student run clinic that has a high standing among the community for providing quality services with patient satisfaction.

I. UW Madison DPT Student Clinic Mission:

Our mission is to provide physical therapy services to the people of Madison in order to fulfill the needs of those uninsured and underinsured while also providing a valuable educational role for students in alignment with the university's core principles of community service and learning.

II. Volunteer Expectations

Volunteers are an integral part of the DPTSC and are required to have punctual attendance and maintain a professional attitude during participation in clinic. DPTSC will be held every Friday of the school’s spring and fall calendar year, unless otherwise specified by the supervising therapist. Students will be divided into groups of 4 to 6 for each client and a minimum of 2 volunteers must be present at each session. It is expected that a 1st year will be paired with a 2nd year. Students need to come to clinic in business casual attire with a UW student name badge. Please bring a black ink pen, scratch paper and any physical therapy tools you may need from any of the 4th or 5th floor labs. The DPTSC will provide students with SOAP note forms, VHI exercise cards, equipment and other tools as needed to see patients.

A few days prior to your clinic date you will receive an e-mail reminder from the DPTSC student coordinator. The e-mail will include any necessary information for your day, and if you have any questions or concerns or you do not receive an email reminder, please contact the DPTSC student coordinator at studentDPTclinic@gmail.com. It is the volunteer’s responsibility to be up to date with all immunizations and safety and infection control training (OSHA). If the student is not current with these requirements please notify the supervising therapist and await further instruction.

INITIAL EVALUATION:

1) Give your client the following forms to complete:
   a. Registration
   b. Health History From/Review of Systems (ROS) checklist
   c. Attendance Policy
   d. Confidentiality and HIPPA
   e. Release of Liability
   f. Medication List*

   *previously emailed to patient but need to confirm completion and review

2) Upon completion, review the ROS checklist and any other forms with the client during the examination.

3) All treatments take about one hour.

4) Complete a goal sheet WITH your client at the completion of the exam with supervising faculty.

5) Prior to the client leaving provide a detailed home exercise program with pictures where applicable.
GENERAL TREATMENT SESSIONS:
1) Ask each client any necessary follow-up questions at the beginning of each session.
2) Prior to the client leaving, provide a detailed home exercise program with pictures where applicable.
3) The group members present at the treatment session will create a SOAP note and all SPT’s must sign prior to leaving the clinic. Each note will then be further reviewed and signed by the supervising therapist.
4) All charts must be returned to the clinic box and will be kept locked in the supervising faculty office.

AT SEMESTER:
1) Each client MUST be re-evaluated at the beginning and end of each semester.

III. Supervising Therapist

As of now, the DPTSC is currently under the supervision of Judy Dewane, PT, DSc, NCS. She is the sole person for decisions of admittance into the clinic. She will attend each DTPSC days and provide interactions with each client and student on a need-varying basis for all aspects of care. She will verbally sign off on treatment protocol/plan of care before administration and will sign off in writing all documentation. In the future, other clinical faculty may serve as mentors for patient care.

Contact Information: Dewane@pt.wisc.edu

IV. Admission/Discharge Criteria

APPROVING CLIENTS FOR ADMISSION
a. All clients admitted into the DPTSC must be medically and psychiatrically stable.

b. All admissions to the DPTSC must be properly assessed for appropriateness of admission by a supervising therapist and student coordinator. The supervising therapist should have sufficient knowledge about the programs and services offered at the DPTSC and must be able to determine if the DPTSC is the most appropriate setting for a particular client.

The following questions must be addressed for every admission consultation:

(1) Why or for what service and by whom is the client being referred to the DPTSC? This includes client/family member concerns/goals, past treatment for this condition, precautions, ability of transportation, willingness to attend and participate, and understanding of treatment provided by student/faculty.

(2) What is the expected length of stay? The expected length of stay determines short-term treatment goals and facilitates discharge planning. This includes setting realistic short-term goals to ensure achievement of goals for care in preparation for discharge and setting long-term goals that describe the anticipated functional ability and state of the client upon discharge.

c. The decision to admit a client to a DPTSC is generally on a first-come first-serve basis adjustable by need and must be based on the client’s need for care, the services defined, and if the services needed are available in the DPTSC. The ultimate decision about an admission is to be made by the DPTSC supervising therapist.
d. Competencies of the DPTSC staff to provide the service a client requires must be evident by the fact that the particular service is considered common practice in the respective DPTSC or training must be provided to ensure staff has the necessary competencies without compromising client’s safety.

e. Clients will be re-evaluated at the beginning of a new semester to determine if continuing care is necessary and/or appropriate.

**DISCHARGE CRITERIA**

A client may be discharged from the DPTSC when:

1. The client has met the treatment goals and no longer needs care.
2. The client requires equipment that the current facility can not accommodate.
3. The individual has limited potential for recovery (e.g. The individual's functional status has remained unchanged or additional functional improvement appears unlikely within a reasonable time frame
4. The overall medical status is such that no further progress is anticipated or only minimal gains that could be expected to be attained with either less intensive therapy program or regular daily activities.
5. Client has received insurance and will pursue care elsewhere.
6. The client shows flagrant disregard for the policies of the facility after being appropriately advised of such policies.

Note: It is not necessary that there is an expectation of complete independence in the activities of daily living; but there should be a reasonable expectation of improvement that is of functional value to the individual, measured against his condition at the start of the rehabilitation program. Additionally, the individual must have no lasting or major treatment impediment that prevents progress (i.e. severe dementia).

**2. Site Information**

**I. Overview**

At this time, the DPTSC is housed in the University of Wisconsin’s Department of Physical Therapy in room 5150 of the Medical Science Center (MSC) at 1300 University Ave. Students and clients will have access to a variety of equipment that is already available at this location. The need for additional equipment will be addressed throughout the year and may be purchased with DPTSC raised funds with the advisement of Judy Dewane.

**II. Transportation/Parking**

As of now, each client provides his or her own transportation. Clients have to pay to park in Parking Lot 20, which is located right next to MSC. The cost for parking is $1 per 30 minutes for the first 2 hours, then $1 thereafter.

**III. Funding**

Funding will be raised using various fund raising activities that may change annually. These funds will be used for transportation costs of patients, exercise equipment, and printing expenses. It will be the responsibility of future 1st and 2nd year coordinators to plan these events.
3. Coordinators

I. 1st Year Responsibility

All incoming students will get a brief overview of DPTSC during orientation/summer term. During the fall term, those interested in becoming the 1st year coordinator will acknowledge interest to Phi Theta. At the end of the fall term, an election will be held in which a coordinator will be determined. The role of the 1st year coordinator will be to gain an understanding of how the DPTSC runs from a needs and functioning standpoint in order to take over as the 2nd year coordinator. The 1st year coordinator’s responsibilities include but are not limited to the following: attend all DPTSC meetings, have an active role in seeing clients at the DPTSC, assist in fund raising as needed, assist in planning the end of the year party, have open communication with the 2nd year coordinator and Judy Dewane, plus attend to tasks that may be delegated by him or her by such individuals.

II. 2nd Year Responsibility

- Update private student DPT Google calendar at the beginning of every semester and give 1st year coordinator password at the end of the year.
- Assign student volunteers their client groups based on availability.
- Email reminders to volunteers about: meetings, schedule changes or any information from the supervising therapist.
- Email client on an as need basis.
- Check email throughout the week to stay up-to-date with all clinic schedule changes and clinic needs.
- Call all new potential clients, ask any outlined screening questions during the phone interview, follow-up with supervising therapist to determine eligibility of the potential client.
- Create and print all documents needed for clinic meetings and volunteers.
- Attend every Friday clinic and aid student volunteers in retrieving equipment and other materials needed during clinic.
- Make charts for any new clients prior to initial evaluation.
- Keep in close contact with the supervising therapist to maintain efficiency and quality with DPTSC.
- Planning necessary funding events with 1st year coordinator.
- Planning end of the year party with 1st year coordinator.

III. 3rd Year Volunteers

Those 3rd year students that would like to continue with the DPTSC are encouraged to still be an active role. These students will not be assigned to group or patient but will act in more of a mentor role.

IV. 2013-2014 Coordinators

1st Year - TBD
2nd Years
Jessica Dietz (jndietz@wisc.edu)
Megan Brothen (mbrothen@wisc.edu)
4. *End of the Year Party*

At the end of the spring semester, there will be a party for all volunteers. Specifics are still to be determined. Details will be communicated via email from the 2nd year coordinator once plans have been arranged.

5. *Documents*

   I. Registration
   
   II. Health History
   
   III. Medication List
   
   IV. Confidentiality and HIPPA
   
   V. Release of Liability
   
   VI. Attendance Policy
   
   VII. Evaluation/Intake Form
   
   VIII. Weekly Treatment/SOAP Note
   
   IX. Home Exercise Blank Form
   
   X. Clinic Informational Flyer
   
   XI. Patient/Client Satisfaction Survey
**REGISTRATION FORM**
(Please Print)

Today’s date:

<table>
<thead>
<tr>
<th>A. PATIENT INFORMATION</th>
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<tbody>
<tr>
<td><strong>Patient’s last name:</strong></td>
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<tr>
<td><strong>Is this your legal name?</strong></td>
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<tr>
<td>[ ] Yes</td>
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<tr>
<td><strong>Street address:</strong></td>
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<tr>
<td><strong>Alternate contact:</strong></td>
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<td>( )</td>
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<tr>
<td><strong>Occupation:</strong></td>
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Referred to clinic by:

Chief Problem:

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<th>B. IN CASE OF EMERGENCY</th>
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<tbody>
<tr>
<td><strong>Name of local friend or relative (not living at same address):</strong></td>
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<tr>
<td><strong>Primary Care Physician and phone number:</strong></td>
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</tbody>
</table>
**DATE:** ______________

**NAME:** ___________________________________________________

**DATE OF BIRTH** ______________

**TOBACCO USE:** YES/NO, IF SO, HOW MUCH PER DAY? _______ FOR HOW LONG? __________ DATE QUIT _________

**ALCOHOL USE:** YES/NO, IF SO, HOW MANY DRINKS PER WEEK? _______

**CAFFEINE:** HOW MUCH PER DAY ________

## PREVIOUS HOSPITALIZATION/SURGERIES

<table>
<thead>
<tr>
<th>FOR WHAT</th>
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## PAST ILLNESSES OF YOURSELF AND FAMILY:

- (Check first box for yourself and/or second box for your immediate family)

### YOU/YOUR FAMILY
- □ □ ALCOHOLISM
- □ □ ANEMIA
- □ □ ASTHMA
- □ □ CANCER/TUMOR
- □ □ DIABETES
- □ □ DRUG ABUSE
- □ □ DEPRESSION
- □ □ EPILEPSY/SEIZURES
- □ □ HEAD INJURY

### YOU/YOUR FAMILY

- □ □ HEART DISEASE
- □ □ HEPATITIS
- □ □ HIGH BLOOD PRESSURE
- □ □ LIVER DISEASE
- □ □ KIDNEY DISEASE
- □ □ LUNG DISEASE
- □ □ MENTAL ILLNESS
- □ □ OSTEOARTHRITIS

### YOU/YOUR FAMILY

- □ □ RHEUMATIC ARTHRITIS
- □ □ STROKE
- □ □ THYROID DISEASE
- □ □ TUBERCULOSIS, TB
- □ □ ULCER IN GI TRACT

### YOU/YOUR FAMILY

- □ □ OTHER 
- □ □ OTHER 
- □ □ OTHER 
- □ □ OTHER 

## REVIEW OF SYSTEMS:

- Please check each item “YES” or “NO” as they relate to your health. If YES, indicate **WHEN**

### CONSTITUTIONAL: **Yes** **No** **When**
- Weight Gain/Loss
- Fatigue
- Fever

### EYES:
- □ □ Glasses/Contacts
- □ □ Eye Pain
- □ □ Change in Vision
- □ □ Double Vision
- □ □ Cataracts

### EAR, NOSE, THROAT:
- □ □ Difficulty Hearing
- □ □ Ringing in Ears
- □ □ Vertigo
- □ □ Sinus Trouble
- □ □ Freq. Sore Throat
- □ □ Decreased Tasting
- □ □ Difficulty Swallowing

### CARDIOVASCULAR:
- □ □ Murmur
- □ □ Chest Pain
- □ □ Palpitations
- □ □ Dizziness
- □ □ Fainting Spells
- □ □ Shortness of Breath
- □ □ Difficulty Lying Flat
- □ □ Swelling Ankles

### ENDOCRINE:
- □ □ Loss of Hair
- □ □ Heat/Cold Intolerance

### RESPIRATORY: **Yes** **No** **When**
- □ □ Cough
- □ □ Coughing Blood
- □ □ Wheezing
- □ □ Chills/Night Sweats

### ALLERGIC/IMMUNOLOGIC:
- □ □ Hives/Eczema
- □ □ Hay Fever

### GASTROINTESTINAL:
- □ □ Heartburn/Reflux
- □ □ Nausea/Vomiting
- □ □ Movements
- □ □ Black/Bloody Bowel Movements
- □ □ Freq. Diarrhea
- □ □ Jaundice

### GENITOURINARY:
- □ □ Burning/Frequency
- □ □ Nighttime
- □ □ Blood in Urine
- □ □ Erectile Dysfunction
- □ □ Abnormal Discharge
- □ □ Bladder Leakage

### HEMATOLOGY/LYMPH:
- □ □ Easy Bruising
- □ □ Gums Bleed Easily
- □ □ Enlarged Glands

### PSYCHIATRIC: **Yes** **No** **When**
- Anxiety/Depression
- Mood Swings
- Difficulty Sleeping
- □ □ SKIN:
- □ □ Rash/Sores
- □ □ Lesions
- □ □ Itching/Burning

### MUSCULOSKELETAL:
- □ □ Fractures
- □ □ Where

### NEUROLOGICAL:
- □ □ Head Trauma
- □ □ Drowsiness
- □ □ Headaches
- □ □ Lightheadedness
- □ □ Insomnia
- □ □ Numbness
- □ □ Burning Sensation
- □ □ Tremors

### OTHER:
- □ □ Memory Loss
- □ □ Other
- □ □ Other
NEW PATIENT – PLEASE COMPLETE THE FOLLOWING

NAME: __________________________________________________     DATE: ________________________

**CURRENT MEDICATIONS:** (Include birth control pills, vitamins, and supplements)

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<tr>
<th>MEDICINE NAME</th>
<th>HOW TAKEN</th>
<th>WHO PRESCRIBES?</th>
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PRIMARY CARE PROVIDER IS ___________________________________ PHONE # __________________

**ALLERGIES:** (Please list any drug, food product, or substance)

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<th>NAME</th>
<th>ADVERSE REACTIONS</th>
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CONFIDENTIALITY AGREEMENT
The UW Madison DPT Student Clinic provides physical therapy students with learning experiences through observation and participation in care of patients. Federal and state laws, as well as professional ethics require that all health science students maintain the confidentiality of patient information to the greatest extent possible. The clinic upholds a commitment to confidentiality very seriously. Exceptions in which confidentiality may be disclosed include the following:
1) When not upholding confidentiality may result in physical harm to others or myself.
2) In instances involving physical or sexual abuse of children or vulnerable adults.

Authorization to Release Information (HIPPA)
I understand that as part of my care, UW Madison DPT Student Clinic maintains health records. Under the Family Educational Rights and Privacy Act (FERPA) and by Wisconsin State Law the use and disclosure of such records maintained by the clinic are protected. Signing this form gives authorization to students and faculty of the clinic for use and disclosure of my health information to carry out treatment as well as discussion for academic advancement. My health information will not be released to anyone else unless it is indicating below. In addition, the clinic may need to contact me in regards to service and care provided. I authorize the clinic to communicate with me about such information as indicated below. I have the right to refuse to sign this authorization but in doing so, the clinic may decline to provide services.

Name: ___________________________ Date of Birth: __/__/____

[ ] I authorize the release of information obtained from UW Madison DPT Student Clinic to the following:
  [] Spouse ______________________________
  [] Child(ren) __________________________
  [] Other ______________________________

[ ] Information is not to be released to anyone.
This Release of Information will remain in effect until terminated by me in writing.

Contact
Please communicate with me by:
[ ] my home phone ________________
[ ] my cell number ________________
[ ] my email ______________________

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call

The best time to reach me is (circle): Sun  Mon  Tue  Wed  Thur  Fri  Sat
  Morning  Afternoon  Evening

Signed: _____________________________ Date: ___/___/___
Release of Liability and Agreement to Treat

In exchange for participation/treatment in the UW Madison, DPT Student Pro Bono Clinic, organized by the faculty and students of the DPT Program in the Department of Orthopedics and Rehabilitation Medicine in the School of Public Health and Medicine, at 1300 University Avenue, Madison, Wisconsin, I agree to the following:

1) I agree to observe and obey all posted rules and warnings, and further agree to follow any oral instructions or directions given by the Physical Therapy Students and PT faculty.

2) I recognize that there are certain inherent risks associated with the above described activity and I assume full responsibility for personal injury to myself and further release and discharge the UW Madison and the UW DPT Program (including the PT students and PT faculty) for injury, loss or damage arising out of my use of or presence upon the facilities of UW Madison, whether caused by the fault of myself, my family, the PT students/PT faculty, or other third parties.

3) I understand that this care is provided by Physical Therapy students under the supervision of a licensed Physical Therapist. I also understand these people are volunteers, and that I will not be charged for their services.

4) I give permission to the UW Madison DPT Students and Faculty to work with me and provide physical therapy services.

I HAVE READ THIS DOCUMENT AND UNDERSTAND IT. I FURTHER UNDERSTAND THAT BY SIGNING THIS RELEASE, I VOLUNTARILY SURRENDER CERTAIN LEGAL RIGHTS.

Participant’s signature ___________________________________  Date ________________

PHOTO RELEASE

I give permission to use my image as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of myself for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the UW Madison DPT Program Web site.

- Deny permission to use my image at all.
- Grant permission to use my image in the following ways (mark all that apply):
  - Limited usage: I want my image used within the DPT program setting only (not in the larger community).
  - Limited usage: I want my image used for educational materials only (not marketing). This could be either within DPT Program or in the larger community. One example of this could be videos in patient education classes.
  - Limited usage: I want my image used on printed materials only (no digital or video use).
  - Unrestricted usage: I give unrestricted permission for my image to be used in print, video, and digital media. I agree that these images may be used by the DPT program for a variety of purposes and that these images may be used without further notifying me. I do understand that my last name will not be used in conjunction with any video or digital images.

Participant’s signature ___________________________________ Date ________________
Attendance Policy

Welcome to the UW Madison DPT Student Clinic. We look forward to getting to know you personally and assisting in your recovery.

We understand that there will be times when you will need to change or cancel an appointment. In order to provide timely care to all of our patients, we do have an attendance policy, which we ask that you review and sign.

1. If you are unable to attend an appointment, please call the clinic as soon as possible at (608)620-5374. A 24-hour notice is appreciated as this may enable the staff to provide care to another patient during the canceled time period.

2. If you are more than 20 minutes late for your appointment, you may be asked to reschedule.

3. If you do not attend two consecutive appointments without giving a cancellation notice, rehabilitation services will be discontinued.

If you have questions regarding this policy, please talk to your physical therapist.

I have read and understand the above policy.

__________________________________                             __________
Client Signature       Date
CLIENT EVALUATION INTAKE INFORMATION

DATE: ________________
CLIENT NAME: ____________________________
STUDENT THERAPIST(S): ________________________

MEDICAL HISTORY

PRIMARY DIAGNOSIS AND REASON FOR SEEKING TREATMENT (CHIEF COMPLAINT):
____________________________________________________________________________________
____________________________________________________________________________________

ONSET DATE: _______________________________________________________________________

____________________________________________________________________________________

HISTORY OF PRESENT ILLNESS (include initial symptoms & how has it changed):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

PREVIOUS REHABILITATION OR THERAPIES/TYPES OF THERAPIES, PLACE OF SERVICE, AND WHEN THEY WERE RECEIVED (include medical tests that have been done):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

SOCIAL HISTORY

LIVING SITUATION: ___________________________________________________________________

____________________________________________________________________________________

ANY ADAPTIVE EQUIPMENT: __________________________________________________________

____________________________________________________________________________________

WORK/SCHOOL STATUS:
____________________________________________________________________________________
____________________________________________________________________________________

ACTIVITY LEVEL & FREQUENCY: ______________________________________________________________________

ARE YOU CURRENTLY DOING A HOME EXERCISE PROGRAM? DESCRIBE IT:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

TRANSPORTATION (Drive or Provider, Company or Friend/Family and what is their number):
____________________________________________________________________________________
____________________________________________________________________________________
HOBBIES/LEISURE INTERESTS:

PERSONAL GOALS & ISSUES YOU HOPE TO ADDRESS:

EVALUATION FINDINGS:

PAIN RATING:

GENERAL OBSERVATIONS (include posture):

MOBILITY (include Level of Independence and Assistance/Device in this section):
  - Bed Mobility:
  - Transfers:
  - Locomotion:
  - Comments/Descriptors(PLEASE FILL THIS SECTION IN):

ROM (ACTIVE / PASSIVE):

MUSCLE TONE/REFLEXES:

SENSATION:

VISION:

BALANCE:

COORDINATION:

ENDURANCE:
OTHER:

ASSESSMENT:

- PROGNOSIS:

- LTG (end of the semester):

- STG:

PLAN:

__________________________________________  ____________
Signature                                      Date
WEEKLY CLINIC SOAP NOTE

Date: ______________________
Client:____________________________
Student Therapist(s):_______________________________________________________
Primary Medical Dx:___________________________________________________________
Chief Complaint:____________________________________________________________

GOALS:
STG:

LTG:
Home Exercise Program

If you have any questions please contact us via email: studentDPTclinic@gmail.com, or you can also contact us through Judy Dewane, PT (Faculty Supervisor for the clinic) at (608)620-5374.
LOCATION:
Medical Science Center 5th Floor
Room 5150
1300 University Ave.
Madison, WI 53705
phone: (608) 620-5374
email: studentdptclinic@gmail.com

TIME:
Fridays by appointment
12:00pm — 1:00pm
or
1:30pm — 2:30pm

PARKING INFORMATION:
Garage #20 University Avenue Ramp
1390 University Ave.
COST (payment by credit card):
$1 per 30 minutes for first 2 hours
$1 per hour thereafter

Mission Statement
Our mission is to provide physical therapy services to the people of Madison in order to fulfill the needs of those uninsured and underinsured while also providing a valuable educational role for students in alignment with the university’s core principles of community service and learning.

ABOUT:
- This is a UW-Madison Doctor of Physical Therapy student run clinic with faculty advisement.
- All services are provided free of charge by the student volunteers. On average two to three students are paired with a client on a weekly basis.
- Services provided: Primarily a neurological rehabilitation focused center (gait, balance, proprioception, coordination training etc.)

*There is limited space available and qualified clients are considered on a first come first serve basis, and according to need. Services are on-going and are available only through scheduled appointment.

Please contact us for more information and to schedule an appointment:
(608) 620-5374
studentdptclinic@gmail.com
Patient/Client Discharge Survey

1. How would you rate your overall experience?

◯  ◯  ◯  ◯  ◯  ◯  ◯  
0  1  2  3  4  5  Excellent
Poor

2. Does the UW DPT Student Clinic and volunteers exemplify a professional clinic?

◯  ◯  ◯  
Not at all  Partially  Yes, completely

3. Did you feel the clinic helped you reach your own personal goals?

◯  ◯  ◯  
Not at all  Partially  Yes, completely

4. Would you recommend this clinic to others in need?

◯  ◯  
No  Yes

5. Suggestions for clinic improvement?


6. Additional Comments/Concerns: