

Patient Name: _____ Phone #: _____ Date: _____

Diagnosis or Impression: _____

ICD-10: _____ Surgery/Injury Date: _____

■ Evaluate and Treat

If you request selective intervention for this patient, please indicate below:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Manual Therapy/ Spinal Manipulation <input type="checkbox"/> ASTYM <input type="checkbox"/> Dry Needling <input type="checkbox"/> Aquatic Therapy* <input type="checkbox"/> Orthotic Fabrication* <input type="checkbox"/> Iontophoresis <input type="checkbox"/> Modalities <input type="checkbox"/> AlterG® Anti-Gravity Treadmill® Therapy* <input type="checkbox"/> Blood Flow Restriction Training* <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Pediatrics* <input type="checkbox"/> Orthopaedic <input type="checkbox"/> Neurological <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Post-operative Rehabilitation <input type="checkbox"/> Therapeutic Exercises | <input type="checkbox"/> Workers' Compensation Services <input type="checkbox"/> Work Conditioning ____ Hrs/Day, ____ Days/Week <input type="checkbox"/> Job Analysis <input type="checkbox"/> Chronic Pain Strategy <input type="checkbox"/> Pain Science Education <input type="checkbox"/> Graded Exercise/Activity <input type="checkbox"/> VR Pain Education/Management <input type="checkbox"/> Stand Up 2 Stenosis Program | <input type="checkbox"/> Women's and Men's Specialty Health* <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Fecal Incontinence <input type="checkbox"/> Chronic Prostatitis/Chronic Pelvic Pain Syndrome <input type="checkbox"/> Rectal Pain <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Pregnancy Related Pain |
|--|--|--|--|

Other Services:

- Massage Therapy* Personal Training*

Specific Instructions:

Avoid/Precautions: _____

Comments: _____

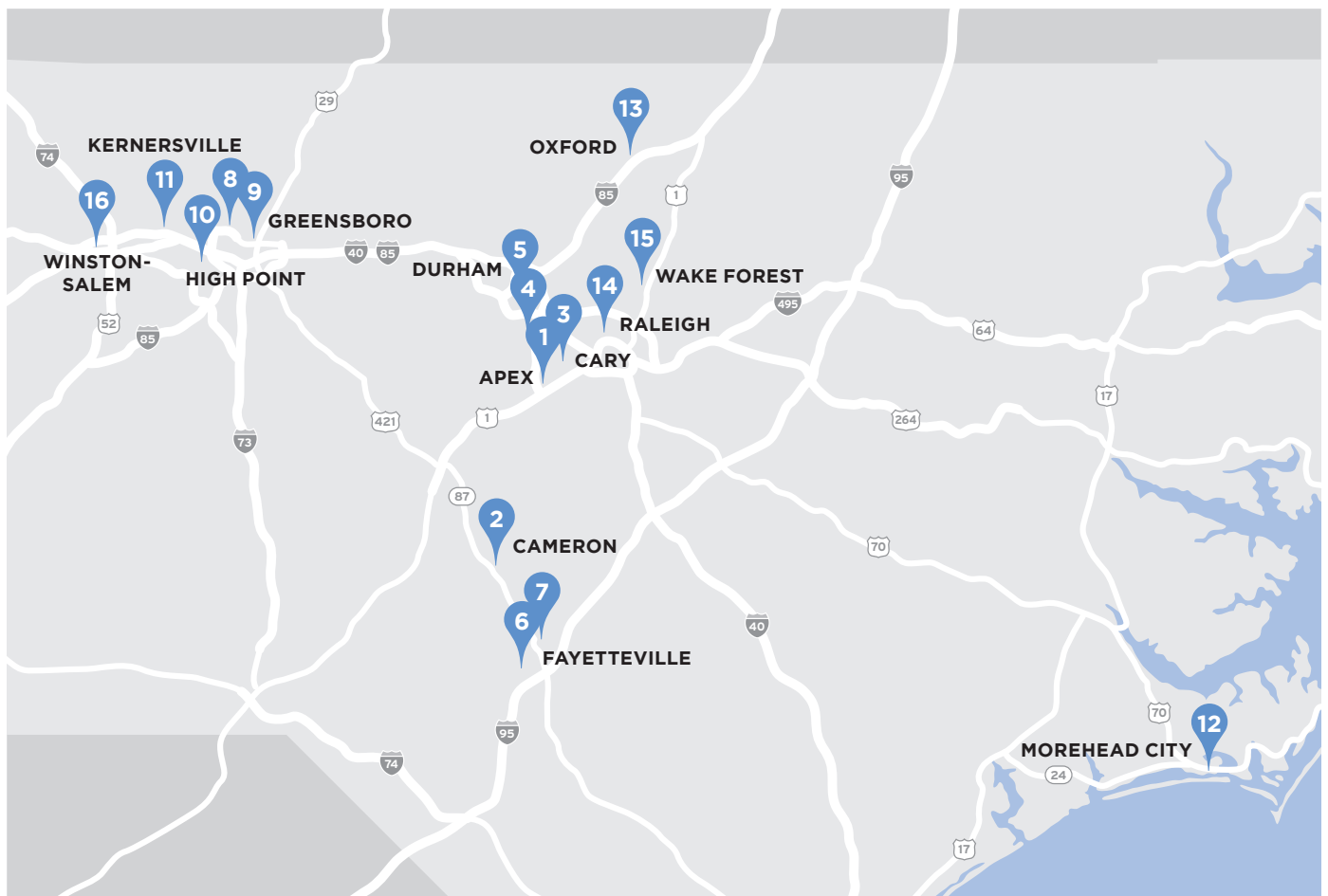
I certify that the treatment is medically necessary and will be reviewed every 30 days.

Referring Provider's Signature: _____

Please print name: _____ Date: _____

*Offered only at select clinics

Medicare requires a physician's signature on the Plan of Care (POC), which will be faxed to you as part of the Initial Exam summary - please fax back promptly. Thank you!



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- | | | | |
|---|---|---|--|
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