

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: _____

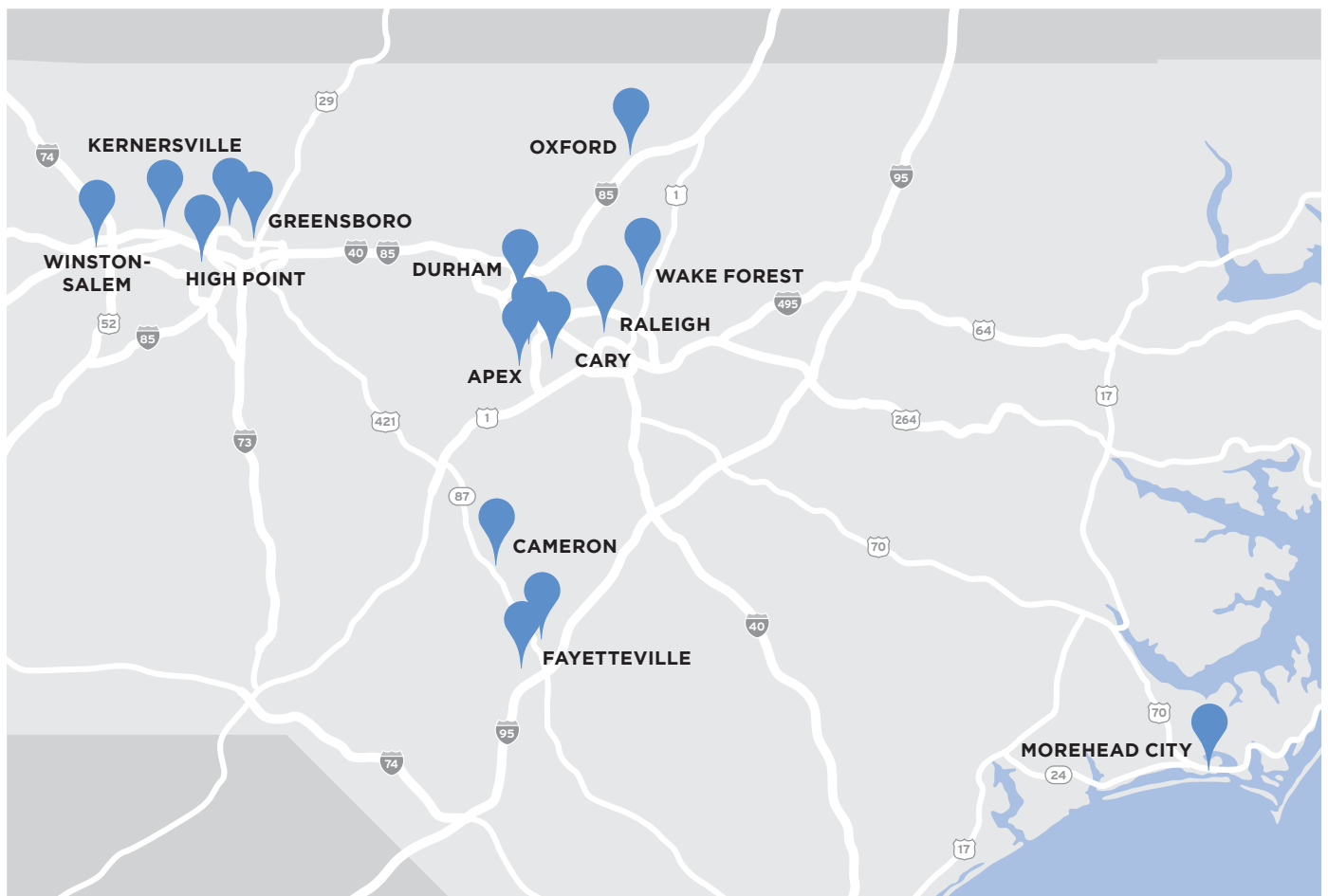
I certify that the treatment is medically necessary and will be reviewed every 30 days.

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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