

BreakThrough

PHYSICAL THERAPY

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"/> Pediatrics*
<input type="checkbox"/> Orthopaedic
<input type="checkbox"/> Neurological
<input type="checkbox"/> Occupational
Therapy | <input type="checkbox"/> Workers' Compensation Services
<input type="checkbox"/> Functional Capacity Evaluation*
<input type="checkbox"/> Work Conditioning
____ Hrs/Day, ____ Days/Week
<input type="checkbox"/> Job Analysis/Job Coaching
<input type="checkbox"/> Fit For Duty Test (for workers
with a job to return to)* | <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
<input type="checkbox"/> Lymphedema |
| <input type="checkbox"/> Aquatic Therapy* | <input type="checkbox"/> Post-operative
Rehabilitation | | |
| <input type="checkbox"/> Pain Science | <input type="checkbox"/> Therapeutic
Exercises | | |
| <input type="checkbox"/> Orthotic Fabrication* | | | |
| <input type="checkbox"/> Iontophoreses | | | |
| <input type="checkbox"/> Modalities | | | |
| <input type="checkbox"/> Other _____ | | | |

Self pay:

- Massage Therapy* Pilates* 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: _____

*Signifies programs are available at select locations.

See back for clinic contact information.

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!

BreakThrough

PHYSICAL THERAPY



1 Winston-Salem
2828 Maplewood Ave., Ste. A
Winston-Salem, NC 27103
336-765-4703

2 Kernersville
853 Old Winston Rd., Ste. 115
Kernersville, NC 27284
336-310-0750

3 Greensboro Braxton Ln.
2105 Braxton Ln., Ste. 101
Greensboro, NC 27408
336-458-3694

4 Greensboro Church St.
1910 N. Church Ste. D
Greensboro, NC 27405
336-274-7480

5 Cameron
1562 Highway 24/87
Cameron, NC 28326
910-499-4544

6 Fayetteville Owen Dr.
1712 Owen Dr.
Fayetteville, NC 28304
910-483-9300

7 Fayetteville Ramsey St.
4140 Ramsey St., Ste. 110
Fayetteville, NC 28311
910-920-4903

8 Apex
1051 Pemberton Hill Rd., Ste. 201
Apex, NC 27502
919-363-3640

9 Cary
981 High House Rd., Ste. 100
Cary, NC 27513
919-388-0111

10 Raleigh
6500 Creedmoor Rd., Ste. 208
Raleigh, NC 27612
919-676-2001

11 Wake Forest
2824 Rogers Rd., Suite 102
Wake Forest, NC 27587
919-229-8363

12 Oxford
110 Main St.
Oxford, NC 27565
919-853-7183

13 Morehead City
303 North 35th St.
Morehead City, NC 28557
252-247-2738

