

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"/> 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*
 Dance Specialty Rehabilitation*
 Medical Therapeutic Yoga*

Specific Instructions:

- Avoid/Precautions: _____

Comments: _____

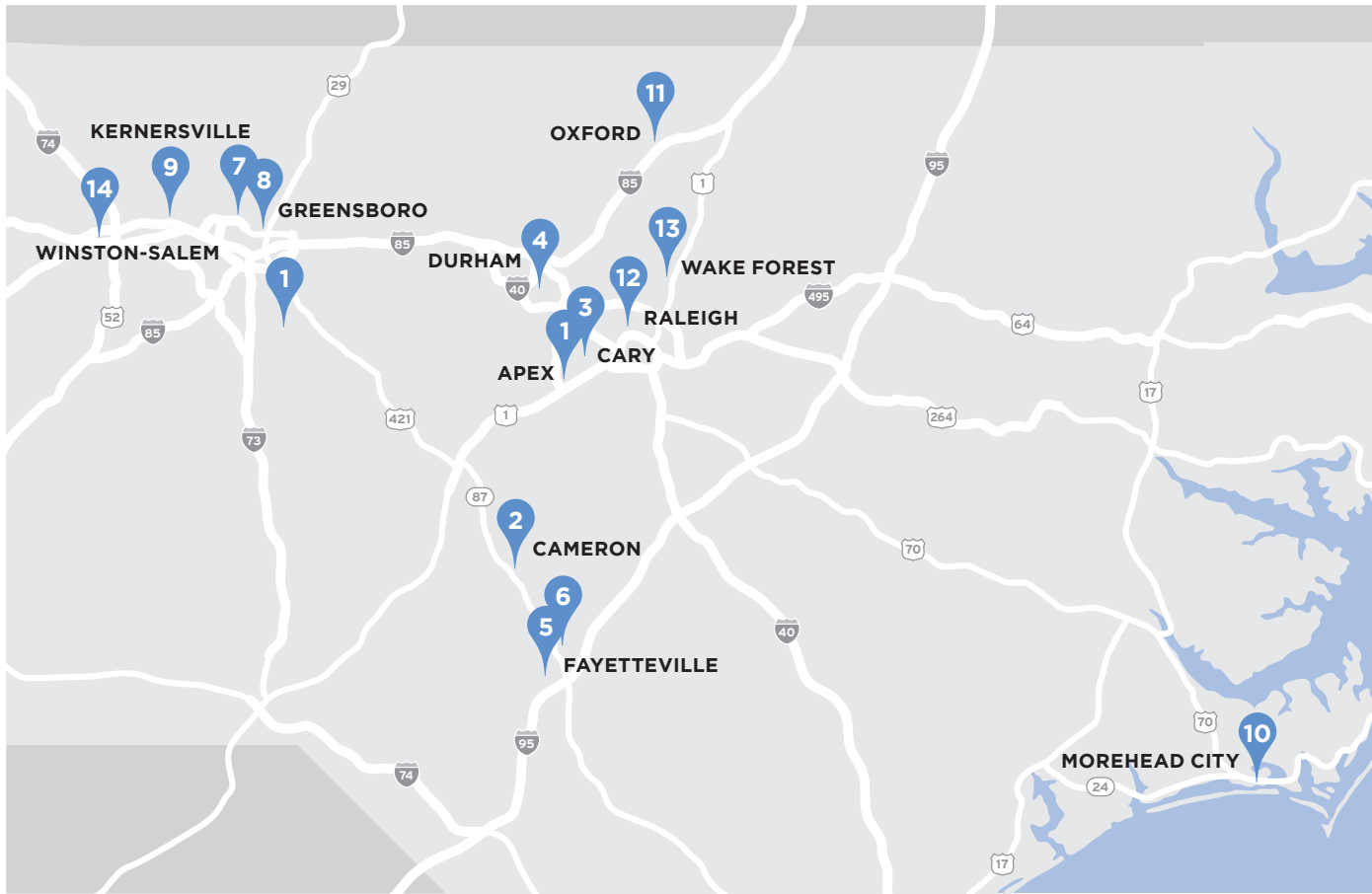
I certify that the treatment is medically necessary and will be reviewed every 30 days.

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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- | | | | |
|--|--|---|--|
| <p>1 Apex
1051 Pemberton Hill Rd., Suite 201
Apex, NC 27502
919-363-3640
Fax: 919-363-3642</p> | <p>5 Fayetteville Owen Dr.
1712 Owen Dr.
Fayetteville, NC 28304
910-483-9300
Fax: 910-483-9302</p> | <p>9 Kernersville
853 Old Winston Rd., Suite 115
Kernersville, NC 27284
336-310-0750
Fax: 336-310-0755</p> | <p>13 Wake Forest
2824 Rogers Rd., Suite 102
Wake Forest, NC 27587
919-229-8363
Fax: 919-229-8356</p> |
| <p>2 Cameron
1562 Highway 24/87
Cameron, NC 28326
910-436-4545
Fax: 910-497-2222</p> | <p>6 Fayetteville Ramsey St.
4140 Ramsey St., Suite 110
Fayetteville, NC 28311
910-920-4903
Fax: 910-920-4910</p> | <p>10 Morehead City
303 North 35th St.
Morehead City, NC 28557
252-247-2738
Fax: 252-240-3882</p> | <p>14 Winston-Salem
1541 Westbrook Plaza Dr.
Winston-Salem, NC 27103
336-765-4703
Fax: 336-765-1396</p> |
| <p>3 Cary
981 High House Rd.
Cary, NC 27513
919-388-0111
Fax: 919-388-8668</p> | <p>7 Greensboro Braxton Ln.
2105 Braxton Ln., Suite 101
Greensboro, NC 27408
336-458-3694
Fax: 336-660-6422</p> | <p>11 Oxford
110 Main St.
Oxford, NC 27565
919-853-7183
Fax: 919-853-7184</p> | |
| <p>4 Durham
1821 Martin Luther King Jr. Pkwy.
Durham, NC 27707
919-748-4980
Fax: 919-816-2012</p> | <p>8 Greensboro Yanceyville St.
1591 Yanceyville St., Suite 400
Greensboro, NC 27405
336-274-7480
Fax: 336-274-8903</p> | <p>12 Raleigh
4701 Creedmoor Rd., Suite 107
Raleigh, NC 27612
919-676-2001
Fax: 919-676-0023</p> | |

