

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:

**Manual Therapy/Spinal Manipulation**

- IASTM
- Dry Needling

Iontophoresis

Modalities

Post-operative Rehabilitation

Therapeutic Exercises

**Workers' Compensation Services**

- Work Conditioning  
\_\_\_\_ Hrs/Day, \_\_\_\_ Days/Week
- Job Analysis

**Chronic Pain Strategy**

- Pain Science Education
- Graded Exercise/Activity
- VR Pain Education/Management

Other: \_\_\_\_\_  
\_\_\_\_\_

Specific Instructions:

Avoid/Precautions: \_\_\_\_\_  
\_\_\_\_\_

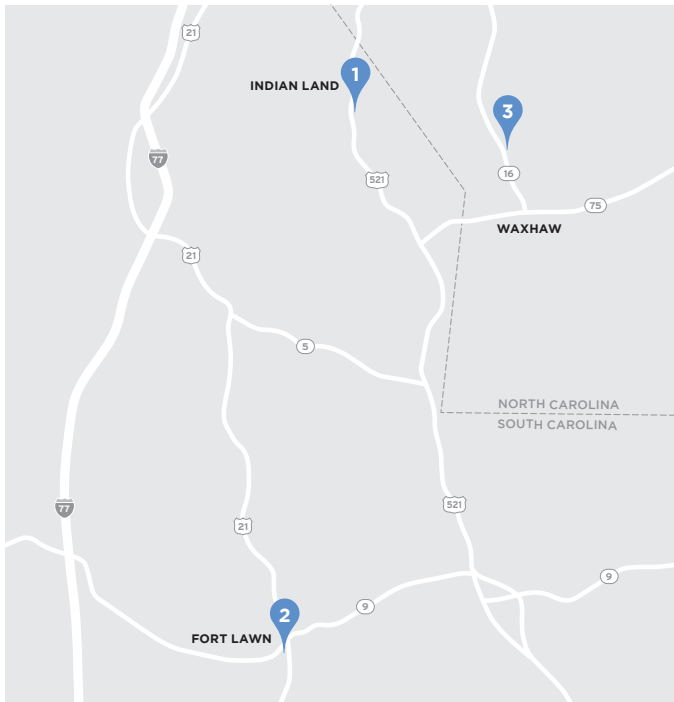
Comments: \_\_\_\_\_  
\_\_\_\_\_

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

Referring Provider's Signature: \_\_\_\_\_

Please print name: \_\_\_\_\_ Date: \_\_\_\_\_

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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