NEW ERA Physical Therapy & Industrial Health Services

615 West Mermod. Carlsbad, NM 88220
Phone: (575)- 200-3465 Fax: (575)- 200-3470

PATIENT NAME: _____ **DOB :** ____/ ____/ _____ **DATE:** ____/____/ ____

PATIENT PHONE: ( ) - _____ - _____ **PATIENT ALTERNATE PHONE:** ( ) - _____ - _____

REFERRING PROVIDER: _____ **PHONE:** ( )-____ - ___ **FAX :** ( )- ___ - ____

DIAGNOSIS: 1. _____ **2.** _____ **3.** _____

Duration of Therapy: Frequency: _____ **a week for** _____ **weeks**

Type of Order: {__} Initial Evaluation & Treatment, {__} Change Existing Plan or Care, {__} Continue Same Plan of Care, {__} Discharge, {__} Hold Therapy, {__} New Diagnosis..

Please Check All That Apply. Call with any questions.

Check	ADULT & PEDIATRIC THERAPY
	Evaluation & Treatment
	Balance & Fall Prevention Evaluation
	Sports Injury Assessment
	Other
Check	**SKILLED THERAPY PRORAMS**
	Arthritis Management
	Injury Prevention & Education
	Neurological Rehabilitation
	Vestibular Rehabilitation
	MODALITIES & THERAPEUTIC PROCEDURES
	Strengthening Exercise
	Range of Motion (ROM) Exercise
	Core Stabilization
	ADL/Transfer Training
	Gait Training,
	Balance Training
	Manual Traction
	Manual Therapy/Joint Mobilization
	Aquatic Therapy
	Kinesiotaping
	Electrical Stimulation
	Ultrasound
	Biofeedback
	Moist Heat
	Adaptive Equipment
	Therapeutic Exercises
	Other:

Check	OTHER SERVICES AVAILABLE
	All PHYSICALS: DOT, Sports, Immigration etc
Check	**Workman's Compensation**
	Work Hardening/Conditioning
	Functional Capacity Evaluation
Check	**GAIT LAB**
	Complete Gait Analysis
	Objective Disability Evaluation
	Other:
Check	**UV LIGHT THERAPY**
	Psoriasis, Vitiligo, Skin Disorders
Check	**INDUSTRIAL HEALTH SERVICES**
	Objective Disability Evaluation
	Pre-Employment Testing
	Post-Offer Employment Testing
	Functional Capacity Evaluation (FCE)
	Return To Work
	Job Performance Analysis (JPA)
	Work & Task Stimulation
	Work Conditions & Hardening
	Positional Tolerance Testing
	Other:

Physician Special Instructions/Comments: _____

Based upon this patient's diagnosis, I have requested the above procedure (s). I hereby feel the tests are medically necessary.

_____ _____ ____/____/____

Doctor/Provider's Printed Name **Doctor/Provider's Signature** **Date**