



# 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
Check	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
	Kinesio Taping
	Electrical Stimulation
	Ultrasound
	Biofeedback
	Moist Heat
	Adaptive Equipment
	Therapeutic Exercises
	Other:

Check	OTHER SERVICES AVAILABLE
	<b>All PHYSICALS:</b>
	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.

Date: \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_  
Doctor/Provider's Printed Name

\_\_\_\_\_  
Doctor/Provider's Signature



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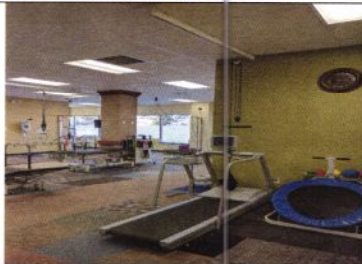
Basic information on some of the tools used at our facility. Call with any questions.

### Gait Lab



**Complete Gait Evaluation  
Objective Disability Evaluation**

### Gait Trainer

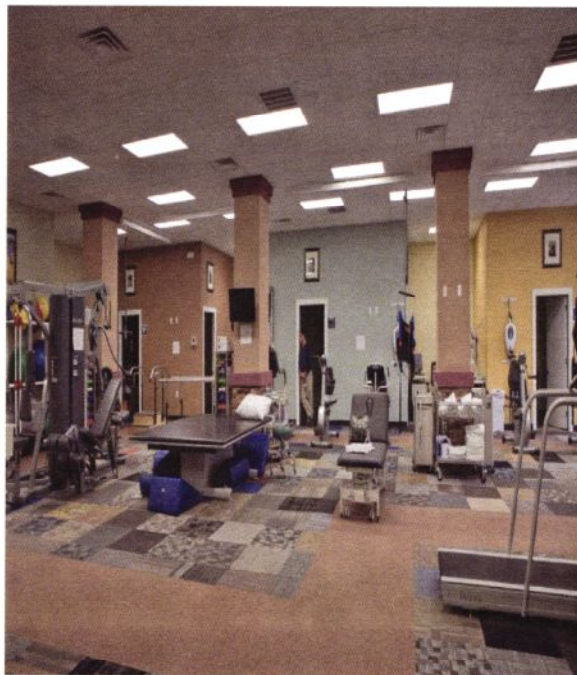


**Musculoskeletal Disorders,  
Neurologic Disorder,  
Fall Prevention & Rehabilitation**

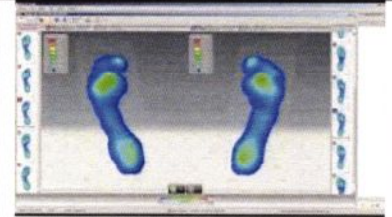
### Virtual Therapy



**Musculoskeletal Disorders,  
Neurologic Disorder,  
Fall Prevention & Rehabilitation**



### Pressure-Walk Analysis



**Diabetic Foot, Orthotics  
6 Minute Walking Test  
Time Up & Go (TUG)**

### Aquatic Therapy

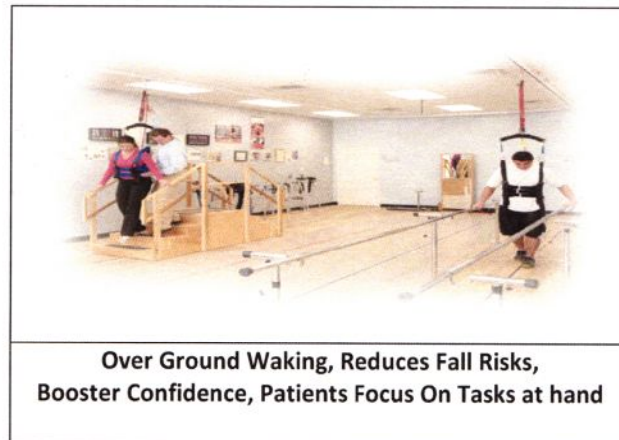


**Musculoskeletal Disorders,  
Neurologic Disorders,  
Balance & Gait Disorders**

### U. V. Light Therapy



**Psoriasis, Vitiligo,  
Skin Disorders**



**Over Ground Waking, Reduces Fall Risks,  
Booster Confidence, Patients Focus On Tasks at hand**

**We appreciate all of your referrals!!!**