R.O.C.K. PHYSICAL THERAPY

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*Patient's Name:*_____ *Patient's DOB*_____

*Diagnosis & ICD-10 Code:*_____ *Patient's Phone #* _____

Patient's Insurance & Subscriber ID: _____

□ Evaluate and Treat
□ Other: (please specify) _____

Specialty Rehab Programs / Procedures:

□ Lumbar Stabilization
□ Cervical Stabilization
□ Orthotics Management
□ Mechanical Traction
□ Rotator Cuff Protocol
□ Vestibular Rehab
□ Kinesiology Taping
□ Electrical Stimulation
□ Pediatric Management
□ TKA Protocol
□ Manual Therapy
□ Gait Training
□ TENS Instruction
□ P/O ACL Rehab
□ THA Protocol
□ Other: _____

Treatment Frequency

□ Therapist Discretion
□ _____times a week for_____weeks

I certify that the prescribed rehabilitation is medically necessary.

_____ _____
Physician's Printed Name & Physician's Signature Date