VIBRANTcare REHABILITATION

TODAY'S DATE: _____

PATIENT INFO.

Name: _____

DOB: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: ( ) _____

Guarantor: _____

REFERRING PHYSICIAN INFO.

Name: _____

MD Signature:_____

Address:_____

City: _____ State: _____ Zip: _____

Phone: ( ) _____

Fax: ( ) _____

Main Contact Person:_____

INSURANCE

Insurance Company: _____

Policy Number: _____

Phone: ( ) _____

Authorization Number: _____

PRIMARY CARE PHYSICIAN (If different from above)

Name: _____

Address: _____

City: _____ Zip: _____

Phone: ( ) _____

☐ **EVAL & TREAT**_____ ☐ **FREQ & DUR.**_____**/PER WK X** _____**/WKS**

- ☐ Physical Therapy
- ☐ Orthopaedic - Adult
- ☐ Orthopaedic – Pediatrics 5+
- ☐ Sports Physical Therapy
- ☐ Musculoskeletal Injuries
- ☐ Occupational Therapy
- ☐ Dry Needling-Limited Locations
- ☐ Vestibular
- ☐ TMD
- ☐ Functional Capacity Evaluation
- ☐ Work Comp Services
- ☐ Aquatic Therapy-Limited Locations
- ☐ Hand Therapy-Limited Locations
- ☐ Breast Care-Limited Locations
- ☐ Women's Health-Limited Locations
- ☐ Other_____

Diagnosis / ICD-10 / Special Instructions:

Preferred VibrantCare Locations: (please check box next to location)

New Mexico Locations:

☐ Albuquerque East ☐ Albuquerque West ☐ Ladera ☐ Los Lunas