
 **NORTH**  
Phone 719-533-1318  
Fax 719-533-1319  
2835 Dublin Blvd.  
Colo. Springs, CO 80918-1662  
(SE Corner of Dublin and Union)

 **SOUTH**  
Phone 719-527-9331  
Fax 719-527-9372  
2989 Broadmoor Valley Rd.  
Colo. Springs, CO 80906-4403  
(SW Corner of Cheyenne  
Mtn. Blvd. and Hwy. 115)

**Joint Effort REHAB LLC**

[www.jointeffortrehab.com](http://www.jointeffortrehab.com)

Patient's Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Precautions/Special Instructions: \_\_\_\_\_

- Physical/Occupational/Speech Therapy Evaluation and Treatment
- Continue Physical/Occupational/Speech Therapy

**Service Provided**

- |   |   |
|---|---|
| <input type="checkbox"/> Manual Therapy                 | <input type="checkbox"/> Therapeutic Exercise                   |
| <input type="checkbox"/> Soft Tissue Mobilization       | <input type="checkbox"/> Home Exercise Program                  |
| <input type="checkbox"/> Myofascial Release             | <input type="checkbox"/> Pilates — Core/Muscle Stabilization    |
| <input type="checkbox"/> Massage Therapy                | <input type="checkbox"/> Health Club Instruction/Orientation    |
| <input type="checkbox"/> ADL/Spine Care                 | <input type="checkbox"/> Mechanical Traction                    |
| <input type="checkbox"/> Hand Therapy                   | <input type="checkbox"/> Electrical Stimulation                 |
| <input type="checkbox"/> Splint Fabrication             | <input type="checkbox"/> Iontophoresis                          |
| <input type="checkbox"/> Orthotics Fabrication          | <input type="checkbox"/> Ultrasound                             |
| <input type="checkbox"/> Ergonomics Education           | <input type="checkbox"/> Balance/Fall Prevention                |
| <input type="checkbox"/> Worksite Evaluation            | <input type="checkbox"/> Infrared/Anodyne                       |
| <input type="checkbox"/> Gait/Crutch Training           | <input type="checkbox"/> Vestibular Rehabilitation              |
| <input type="checkbox"/> Functional Capacity Evaluation | <input type="checkbox"/> Temporomandibular Joint Disorder (TMJ) |
| <input type="checkbox"/> Burn Care                      | <input type="checkbox"/> Other: _____                           |
| <input type="checkbox"/> Speech                         |   |

**Home Supplies**

- |  |   |
|--|---|
| <input type="checkbox"/> Therapy Ball                | <input type="checkbox"/> Home Mechanical Traction |
| <input type="checkbox"/> Therapy Cane                | <input type="checkbox"/> Brace/Support            |
| <input type="checkbox"/> Home Electrical Stimulation | <input type="checkbox"/> Lumbar/Cervical Pillow   |
| <input type="checkbox"/> Other: _____                |   |


**Frequency:**  Daily  3x/week  2x/week  PRN  Other \_\_\_\_\_

**Duration:** \_\_\_\_\_

*I certify that Physical/Occupational/Speech Therapy is medically necessary.*

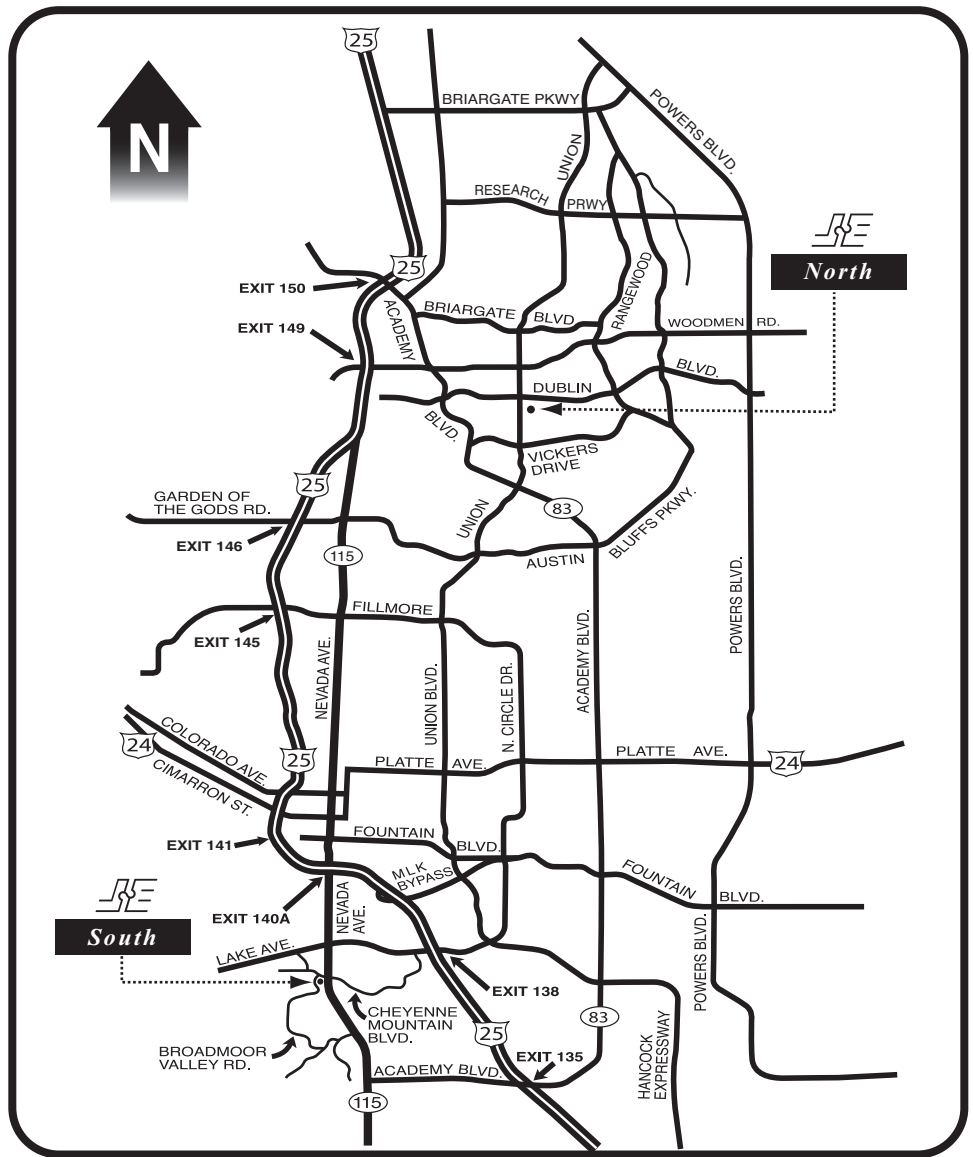
**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patients are responsible for verifying their insurance benefits for Physical/Occupational/Speech Therapy services.

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Most Insurances accepted. We will call to get benefit and verify authorization for you.