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**

☐ Orthopedic - Adult
☐ Orthopedic – Pediatrics 5+
☐ Sports Physical Therapy
☐ Musculoskeletal Injuries
☐ Other _____

☐ Dry Needling-Limited Locations
☐ Vestibular Rehabilitation
☐ TMD
☐ Functional Capacity Evaluation

☐ Workers' Comp Services
☐ Aquatic Therapy-Limited Locations
☐ Hand Therapy
☐ Post-Op Therapy
☐ Women's Health-Limited Locations

Diagnosis / ICD-10 / Special Instructions:

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

West Valley Locations:

☐ Glendale ☐ Goodyear ☐ Central Phoenix

☐ Peoria ☐ Greenway ☐ Bethany

East Valley Locations:

☐ Casa Grande ☐ Tempe

☐ East Chandler ☐ Mesa