



TREATMENT PRESCRIPTION

Name _____ Date _____
 Diagnosis _____ ICD 9 Code _____
 Medical Precautions _____
 1 2 3 4 5 Times/Week _____ Weeks _____ As Needed

- | | |
|--|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Work Conditioning Program |
| <input type="checkbox"/> Industrial Rehabilitation | <input type="checkbox"/> Work Risk Analysis |
| <input type="checkbox"/> Ergonomic/Work Risk Job Site Assessment | <input type="checkbox"/> Injury Prevention Program |
| | <input type="checkbox"/> Functional Capacity Evaluation |

EVALUATE AND TREAT

COMMENTS: _____

I hereby certify these services as medically necessary for the patient's plan of care.
 Physician's Printed Name _____
 Physician's Signature _____ Date _____
 UPIN# _____ FAX# _____

For map & locations, see reverse side.



VibrantCare Rehabilitation Locations

- 1 Tucson East Center**
 6246 E. Pima St., Ste. 160
 Tucson, AZ 85712
 520-721-0319
 FAX 520-733-5810

- 2 Tucson West Center**
 5669 N. Oracle, Ste. 2202
 Tucson, AZ 85704
 520-888-1317
 FAX 520-292-3158

- 3 Casa Grande Center**
 1355 E. Florence Blvd., #137
 Casa Grande, AZ 85222
 520-836-7996
 FAX 520-836-5299