



**Indian Harbour Beach**

I.H.B. Professional Plaza  
2060 HWY A1A, Suite 306  
Indian Harbour Beach, FL 32937

PH: 321-773-1778  
F: 321-773-1737

**Melbourne**

1747 Evans Rd.  
Suite 102  
Melbourne, FL 32904

PH: 321-768-6119  
F: 321-768-1710

**Palm Bay**

5200 Babcock St.  
Suite 202 (2nd Flr.)  
Palm Bay, FL 32905

PH: 321-726-4150  
F: 321-726-4152

Patient's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Surgery: \_\_\_\_\_ Sx Date: \_\_\_\_\_

**Physical Therapy**  
EVALUATE AND TREAT

- Cervical
- Shoulder
- Elbow
- Thoracic
- Lumbar
- Hip
- Knee
- Ankle
- Foot

- Spine Management Program
- Vestibular Rehab Program
- Gait and Balance Program
- Women's Urinary Incontinence

**Occupational Therapy**  
EVALUATE AND TREAT

- Shoulder
- Elbow
- Wrist
- Hand
- Custom Splinting
  - Static
  - Dynamic
- Carpal Tunnel Program

**Functional Capacity Evaluation**

**Respiratory Therapy**  
EVALUATE AND TREAT

- Breathing Retraining
- Strength/Endurance
- Patient Education

**Speech Therapy**  
EVALUATE AND TREAT

**Social/Psychological Services**  
EVALUATE AND TREAT

**Other:**

Frequency of Treatment:  As Needed  Two times a week  Three times a week

Duration: \_\_\_\_\_ weeks.

My signature on this form authorizes this treatment as Medically Necessary:

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_