ACC - RUSK INSTITUTE OF REHABILITATION MEDICINE
240 East 38th Street • 16th Floor • New York, NY 10016
Telephone: (212) 263-6033 • Website: www.ruskinstitute.org

Outpatient Prenatal/Postpartum Physical Therapy Referral Form

FAX to the ACC RUSK INTAKE / REGISTRATION at (212) 263-0113

Date: ________________________

Patient Name: (Last)___________________________(First)_____________________________________

Date of Birth:__________________ Social Security:____

Patient Address: ____

Patient Phone: (H)___________________(W)________________________(C)_____________________

Primary Insurance:____________________________________

Policy ID#:_______________________________________Insured Name:_________________________

Secondary Insurance:__________________________________

Policy ID#:_______________________________________Insured Name:_________________________

Medical Diagnosis: ____________________________ ICD code:_________________

_____Obstetrical Low Back Pain
_____Joint Pain - Pelvis
_____Neck Pain/Cervicalgia
_____Sacroiliac Dysfunction
_____Diastasis Recti
_____Coccygodynia
_____Sciatica (pain)
_____Other________________________

Prescription for Evaluation and Treatment Including: (please select ALL that apply)
_____Therapeutic Exercise, Manual Therapy, Self Care/Patient education, Therapeutic Activities (baby care), Neuromuscular Re-education
_____Hot pack/Cold pack
_____TENS, ESTIM, Ultrasound, Biofeedback
_____Other____

Onset Date: __________

Precautions: ____

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Physician Order Frequency and Durations: ____

Physician's Name/Specialty (Please Print) ____

NPI#: ________________________ License Number:________________ UPIN:________________

Physician's address:____

Office Telephone: (______)_____________________ Office Fax: (______)______________________

Physician's Signature:____