NYU Medical Center **RUSK INSTITUTE** of Rehabilitation Medicine

REFERRAL FOR OUTPATIENT **PELVIC FLOOR PHYSICAL THERAPY**

FAX to the RUSK BUSINESS OFFICE (212) 263-0113

Date: _____

Patient Name: _____
Patient Date of Birth: _____ Patient Social Security Number: _____
Patient Telephone Number: Contact 1: (_____)_____-_____
Contact 2: (_____)_____-_____
Patient Address: _____
_____
Primary Insurance: _____ Policy Number: _____ Insured Name: _____
Secondary Insurance: _____ Policy Number: _____ Insured Name: _____

Medical Diagnosis: _____

_____Female Stress Incontinence
_____Urge Incontinence/Detrusor Instability
_____Urinary Frequency
_____Muscle Weakness
_____Muscle Spasm
_____Interstitial Cystitis
_____Vaginismus
_____Vulvodynia/Vestibulitis
_____Muscle Pain
_____Other _____

Onset Date: _____

Prescription for: (please select)
_____ Manual therapy, therapeutic exercise, neuromuscular re-ed, body mechanics, home exercise program, modalities (PRN: US, E-stim, hot pack / cold pack, biofeedback)
_____ Other

Precautions: _____
Frequency and Duration: _____

Physician's Name (Please Print): _____
License Number: _____ UPIN: _____ NPI#_____
Office Telephone: _____ Office Fax: _____
Physician's Signature: _____