Referring physician:

____

Address:____________________

____

____

Phone:____________________

Fax:______________________

Referred to:

SENSORY THERAPEUTICS INC.
210 Jupiter Lakes Blvd.
Bldg. 4000, Suite 201
Jupiter, Fl 33458
(561) 745-0028 Fax (561) 745-0833
www.sensorytherapeutics.com

PATIENT:______________________________ **TELEPHONE #**:______________

DIAGNOSIS:__________________________ **ICD 10 CODE**:______________

DIAGNOSIS:

_______ ATAXIC GAIT ABNORMALITY R26.0
_______ BPPV H81.1___
_______ DIZZINESS R42
_______ DYSEQUILIBRIUM R42
_______ UNSTEADINESS R26.81
_______ TINNITUS H93.1____
_____ LABYRINTHINE DYS H83.2x___
_____ LABYRINTHITIS H83.0___
_____ MENIERE'S DISEASE H81.0____
_____ DIFFICULTY WALKING R26.2
_____ NEURONITIS H81.2___
_____ HISTORY OF FALLS Z91.81

PROBLEM LIST:

______Vertigo/Dizziness (Perceptual Deficits)
______Dysequilibrium (Incoordination)
______Impaired Visual/Vestibular Interaction
______Impaired Postural Orientation
______Gait Disturbance Unrelated to Joint 917.9
_______Impaired Sensory Organizational Skills
_______Impaired / Unsafe Balance
_______Positional Change Symptoms
_______Positional Vertigo
_______Ringing in the Ears

EVALUATE AND TREAT________
ONSET DATE__________________

_______Occupational Therapy
_______Physical Therapy

TREATMENT LIST:

________Neuromuscular Re-education
________Therapeutic Activities
________Training in ADL's
________Visual-Vestibular Activities
_________Therapeutic Exercises
_________Positional Exercises
_________Physical Performance Testing
_________Electrical Stimulation

Recommended frequency ______X per week for _______weeks or _________establish treatment frequency & duration per evaluation. Physician's follow up on _____________.

I certify that the rehabilitation services mentioned above are medically necessary and authorized by me, that this patient is under my care, and that the plan of treatment will be reviewed by me on a regular basis.

PHYSICIAN:__________________________________ **DATE**:_______________