

COMPU-TRAX

OF NEW YORK

VARIANCE
SUBMISSION
AND
TRACKING
SERVICE

(Please complete this form and fax to Compu-Trax at 716-662-1808. If your office utilizes a patient intake form that contains any of the following information, you may attach a copy to this form when faxing to our office)

Last Name: _____ **First Name:** _____ **Eval. Date:** _____

Referring Physician: _____

Involved Body Region: Back Neck Shoulder Knee Other _____

Planned Treatment: *(check all that apply)*

Therex Heat/Ice Stim Ultrasound Phonoph. Whirlpool
 Traction Laser Iontoph. Aquatics Functional Balance
 Manual Massage

1. Has this patient received any physical therapy related to this injury since 12/1/2010, including the current facility, another facility, or home therapy? YES NO

If "YES," please list the location/s & dates: _____

2. Has the patient undergone any surgery related to this injury? YES NO

If "YES," please list surgery and date: _____

Additional Info: _____

Facility Name: _____

Prepared by: _____

Date Submitted: _____

The information contained within this document is confidential information and as such is entitled to all the protections afforded by the Federal Health Insurance Privacy and Portability Act (HIPPA). If you receive this information in error, please destroy it immediately and inform Compu-Trac by calling 716-662-1808.