



NURSING REHABILITATION, LLC

Debra Brothers-Klezmer, BSN; RN-BC; CRRN; NCTMB

42 DiAuto Drive
Randolph, MA 02368
T: 781-986-6443
F: 781-986-4837



Welcome to our office!

In order to serve you properly, we will need the following information. (Please Print) THANK YOU!

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

DAYTIME PHONE: _____ EVENING PHONE: _____

CELL PHONE: _____ SS#: _____

EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____

PHONE: _____

DIAGNOSIS: _____

Worker's Compensation Claim? Yes No Claim#: _____

Insurance Co.: _____ Phone#: _____

Address: _____

Contact: _____

Motor vehicle accident or any liable injury related diagnosis? Yes No

Date of Accident: _____

In case of emergency notify: _____ Phone: _____

AUTHORIZATION FOR TREATMENT AND RELEASE OF RECORDS:

I hereby authorize the performance of services by DBK Nursing. This care is provided at my request. I further authorize the ongoing release of medical and/or billing information regarding my care as necessary

Signature: _____ Date: _____



NURSING REHABILITATION, LLC

Debra Brothers-Klezmer, BSN; RN-BC; CRRN; NCTMB

42 DiAuto Drive
Randolph, MA 02368
T: 781-986-6443
F: 781-986-4837

REHABILITATION • PAIN-MANAGEMENT • MIND/BODY • MEDICAL MASSAGE



Date: _____

Patients Name: _____

Diagnosis: _____

Treatment Plan:

- | | |
|--|---|
| 1) ___ EVALUATE and TREAT
(per clinician's finding) | 8) ___ Relaxation Training |
| 2) ___ Craniosacral Therapy | 9) ___ Trigger Point Therapy |
| 3) ___ Lymphatic Drainage | 10) ___ Cold Laser Therapy |
| 4) ___ Myofascial Release | 11) ___ Iontophoresis |
| 5) ___ Therapeutic Activities | 12) ___ Home Care Program |
| 6) ___ Mind/Body Therapies | 13) ___ Family Education |
| 7) ___ Breath Work | 14) ___ Patient Education for Self-Help |
| | 15) ___ Medical Massage |

Expected Frequency: _____ x/week Duration: _____ weeks

Rehabilitation Potential: ___ Excellent ___ Good ___ Fair ___ Poor

Physician's Comments: _____

Physician's Signature: _____ UPIN: _____

**THIS CERTIFICATION FORM AND PHYSICIANS SIGNATURE
INDICATES THE MEDICAL NECESSITY OF TREATMENT!
THANK YOU!**

Main Office:
42 Diauto Drive
Randolph, Ma 02368
(781) 986-6443
Fax (781) 986-4837