

**THERAPY PRESCRIPTION**



- PRIVATE \_\_\_\_\_
- NO FAULT TREATMENT PLAN
- WORKERS COMPENSATION TREATMENT PLAN

- Kailua Clinic**  
Ph: 261-4321 ♦ Fax: 261-4320
- Kaneohe Clinic**  
Ph: 235-5398 ♦ Fax: 235-6359
- Honolulu Clinic**  
Ph: 521-4922 ♦ Fax: 521-4921

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient's Contact Number \_\_\_\_\_ Date of Injury/Surgery \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD-9 Code \_\_\_\_\_

Precautions \_\_\_\_\_

**OUR SERVICES**

**Evaluate and Treat**

**PHYSICAL THERAPY**  
\_\_\_\_\_ x per week for \_\_\_\_\_ weeks. Total \_\_\_\_\_

**AQUATIC PHYSICAL THERAPY**  
\_\_\_\_\_ x per week for \_\_\_\_\_ weeks. Total \_\_\_\_\_

**MASSAGE THERAPY** by a Licensed Massage Therapist  
For Workers Comp/No Fault Insurance Patients  
\_\_\_\_\_ x per week for \_\_\_\_\_ weeks. Total \_\_\_\_\_

**WORK HARDENING & CONDITIONING PROGRAMS** (Kaneohe Clinic)  
\_\_\_\_\_ x per week for \_\_\_\_\_ weeks. Total \_\_\_\_\_

- Manual Therapy**  
Joint Mobilization  
Manual Traction  
Myofascial Release  
Strain-Counterstrain

- Modalities**  
Mechanical Traction  
Electrical Stimulation  
Ultrasound

- Therapeutic Exercises**  
Home Exercise Program  
Postural Education/Ergonomics  
Strengthening
- Neuromuscular Re-Ed**  
CVA / Stroke Recovery  
Coordination / Proprioception

**Other**  
\_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician's Name (printed) \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**FOR THERAPY OFFICE USE ONLY**

Treatment plan start date \_\_\_\_\_ end date \_\_\_\_\_ estimated cost \$ \_\_\_\_\_

Company \_\_\_\_\_ Employer \_\_\_\_\_

Adjuster \_\_\_\_\_ Ph \_\_\_\_\_ Fax \_\_\_\_\_

Claim No. \_\_\_\_\_  Approved  Denied