

PT HAWAII

PHYSICAL THERAPY

PT HAWAII - HONOLULU

500 ALA MOANA BLVD 6D,
HONOLULU, HI 96813

PT HAWAII - WAIPAHU

94-801 FARRINGTON HWY,
WAIPAHU, HI 96797

PT HAWAII - KAPOLEI

599 FARRINGTON HWY BLDG 2,
KAPOLEI, HI 96707

PT HAWAII - KAILUA-KONA

75-184 HUALALAI RD,
KAILUA-KONA, HI 96740

PHONE: (808) 680-9123 • FAX: (808) 680-9889

REHABILITATION REFERRAL AND TREATMENT PLAN**DIAGNOSIS/ ICD-10 CODE**

PATIENT NAME: _____

DATE OF BIRTH: _____

PHONE: _____

DATE OF INJURY/ SURGERY: _____

INSURANCE CARRIER: _____ ☐ NO FAULT ☐ WORK COMP

☐ **EVALUATE AND TREAT**

AQUA THERAPY AND/OR PHYSICAL THERAPY

☐ **PHYSICAL THERAPY ONLY**☐ **AQUA THERAPY ONLY (WAIPAHU ONLY)**☐ **WORK CONDITIONING**☐ **MASSAGE THERAPY**☐ **FCE - FUNCTIONAL CAPACITY EVALUATION (OAHU ONLY)**☐ **LYMPHEDEMA THERAPY (OAHU ONLY)**☐ **SPECIAL INSTRUCTIONS/ PRECAUTIONS**

WORKER'S COMPENSATION/ NO FAULT CLAIMS*MEASURABLE GOALS/OBJECTIVES***DECREASE:**

☐ TENDERNESS/ TIGHTNESS

☐ SWELLING

☐ PAIN

_____ FR _____ To _____

INCREASE:

☐ ENDURANCE

☐ ROM/ MOBILITY

_____ FR _____ To _____

_____ FR _____ To _____

INCREASE:

☐ Functional Activity Tolerance

☐ Strength/ Stability

_____ FR _____ To _____

_____ FR _____ To _____

EDUCATE:

☐ HOME EXERCISE PROGRAM

☐ BODY MECHANICS ADL'S

☐ SYMPTOM MANAGEMENT

TREATMENT FREQUENCY _____ VISITS/WEEK FOR _____ WEEKS TOTAL VISITS _____

ESTIMATED TREATMENT DATES _____ To _____ COST _____

ADJUSTER NAME _____ SIGNATURE _____

CONTACT _____ FAX _____

CLAIM # _____ ☐ APPROVED ☐ DENIED

PHYSICIAN NAME : _____ **SIGNATURE:** _____ **DATE:** _____

PT HAWAII

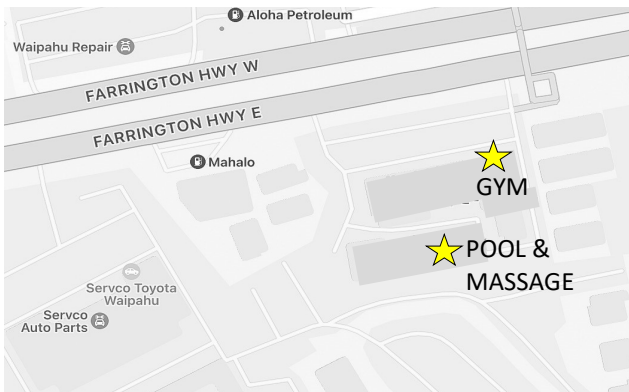
PHYSICAL THERAPY



PT HAWAII - HONOLULU

500 ALA MOANA BLVD 6D

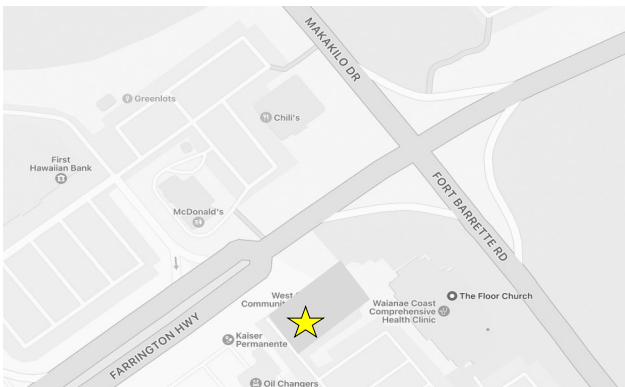
HONOLULU, HI 96813



PT HAWAII - WAIPAHU

94-801 FARRINGTON HWY EAST

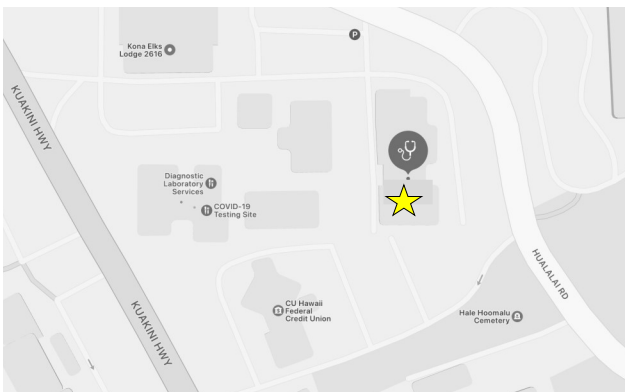
WAIPAHU, HI 96797



PT HAWAII - KAPOLEI

599 FARRINGTON HWY BLDG 2

KAPOLEI, HI 96707



PT HAWAII - KAILUA-KONA

75-184 HUALALAI RD STE 302

KAILUA-KONA, HI 96740