THERAPY PRESCRIPTION

FUKUJI & LUM
PHYSICAL THERAPY ASSOCIATES

☐ **Kailua Clinic**
Ph: 261-4321 ◆ Fax: 261-4320

☐ **Kaneohe Clinic**
Ph: 235-5398 ◆ Fax: 235-6359

☐ **Windward Occupational Rehab Center (W.O.R.C.)**
Ph: 234-5353 ◆ Fax: 234-5858

☐ **Honolulu Clinic**
Ph: 521-4922 ◆ Fax: 521-4921

☐ **PRIVATE** _____
☐ **NO FAULT TREATMENT PLAN**
☐ **WORKERS COMPENSATION TREATMENT PLAN**

Patient's Name _____ Date of Birth _____

Patient's Contact Number _____ Date of Injury/Surgery _____

ICD-9 Code _____ Diagnosis _____

ICD-9 Code _____ Diagnosis _____

Precautions _____

OUR SERVICES

☐ **PHYSICAL THERAPY**

_____x per week for _____weeks. Total _____

☐ **AQUATIC PHYSICAL THERAPY** - Kokokahi YWCA Pool

_____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** - W.O.R.C.

_____x per week for _____ weeks. Total _____

☐ **FUNCTIONAL CAPACITY EVALUATION (F.C.E.)** - W.O.R.C.

☐ ***Evaluate and Treat***

☐ **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 OFFICE USE ONLY

Treatment plan start date _____ end date _____ estimated cost $ _____

Company _____ Employer _____

Adjuster _____ Ph_____ Fax_____

Claim No. _____ ☐ Approved _____ ☐ Denied _____