

THERAPY PRESCRIPTION



fukujilumpt.com

- 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 Code _____ Diagnosis _____

ICD Code _____ Diagnosis _____

Precautions _____

EVALUATE & TREAT

PHYSICAL THERAPY **CLINIC** **MOBILE**

_____ x per week for _____ weeks. Total _____

AQUATIC PHYSICAL THERAPY - W.O.R.C.

_____ 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.

Manual Therapy

- Joint Manipulation
- Joint Mobilization
- Myofascial Release
- Strain-Counterstrain
- Soft Tissue Mobilization
- Gaston / IASTM
(Instrument Assisted
Soft Tissue Mobilization)

Therapeutic Exercises

- Strengthening
- ROM/Flexibility
- Postural Education / Ergonomics
- Home Exercise Program

Neuromuscular Re-Ed

- Gait Training
- Coordination / Proprioception
- CVA / Stroke Recovery

Modalities

- Mechanical Traction
- Electrical Stimulation
- Ultrasound

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 _____