THERAPY PRESCRIPTION

FUKUJI & LUM
PHYSICAL THERAPY
fukujilumpt.com

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

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

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

☐ **Kaneohe Clinic -Work Comp/No Fault**
Windward Occupational Rehab Center (W.O.R.C.)
Ph: 234-5353 ◆ Fax: 234-5858

☐ **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** – Kaneohe & Downtown HNL

_____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
Graston / IASTM
(Instrument Assisted Soft Tissue Mobilization)

Modalities
Mechanical Traction
Electrical Stimulation
Ultrasound

Therapeutic Exercises
Strengthening
ROM/Flexibility
Postural Education / Ergonomics
Home Exercise Program

Neuromuscular Re-Ed
Gait Training
Balance Training
Coordination / Proprioception
CVA / Stroke Recovery

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 _____