PELVIC PHYSICAL THERAPY PRESCRIPTION

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FUKUJI & LUM
PHYSICAL THERAPY

☐ **Kailua Clinic**
Kailua Medical Arts Bldg
407 Uluniu Street, Suite 301
Kailua, HI 96734

☐ **Kaneohe Clinic**
Kokokahi YWCA
45-035 Kaneohe Bay Drive
Kaneohe, HI 96744

PATIENT'S INFORMATION

Full Name: _____ Date of Birth: _____

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

ICD Code: _____ Diagnosis: _____

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- ☐ Urinary Incontinence (stress, urge, mixed)
- ☐ Overactive Bladder
- ☐ Pelvic Organ Prolapse
- ☐ Pelvic Floor and Core Weakness
- ☐ Pelvic Pain Conditions
- ☐ Male Pelvic Conditions
- ☐ Post-Operative Care
- ☐ SPD/PGP
- ☐ Diastasis Recti
- ☐ Lumbosacral Dysfunction
- ☐ Pre/Postpartum Conditions
- ☐ Colorectal Conditions
- ☐ Other _____

Precautions/Contraindications: _____

_____

☐ **EVALUATE & TREAT** per therapist discretion

_____ x per week for _____ weeks. Total _____

TREATMENT:

- ☐ Bladder/Bowel Retraining
- ☐ Biofeedback/sEMG
- ☐ Vaginal Dilator Instruction
- ☐ Other _____
- ☐ Manual Therapy
- ☐ Therapeutic Exercise
- ☐ Neuromuscular Re-Education
- ☐ Home Exercise Program

Physician's Signature _____ Date: _____

Physician's Name (Print) _____ Phone: _____ Fax: _____