HAWAII PHYSICAL THERAPY PRESCRIPTION

□ Worker's Comp Treatment Plan
□ No-Fault Treatment Plan
□ Private Insurance
□ Other

Patient: _____ **Insurer:** _____
Phone: (H) _____ **(W)** _____ **(C)** _____ **Claim #:** _____
Date of Birth: _____ **Date of Injury:** _____ **Adjuster:** _____

□ **Physical Therapy** (Frequency _____ x/wk. for _____ wks.) from _____ to _____.
□ **Work Conditioning Program** (3 days/wk., 2-4 hrs. /day for ___wks.) from_____ to _____.
□ **Work Hardening Program** (3 days/wk., 2-4 hrs. /day for ____wks.) from_____to _____.

Diagnosis #1 _____ ICD-10 _____
Diagnosis #2 _____ ICD-10 _____
Diagnosis #3 _____ ICD-10 _____

Pertinent Medical History _____

Special Instructions _____

Goals/Objectives _____

☐ **Evaluate and Treat**

	Modalities		Active Therapeutic Exercise		
	Low Level Laser Therapy		Cardiovascular/Endurance		Neck Program
	Electrical Stimulation		ROM/Flexibility		Shoulder Program
	Ultrasound		PRE's/Strengthening		Elbow Program
	Iontophoresis/Phonophoresis		Balance/Proprioception		Wrist/Hand Program
	Whirlpool/Paraffin		Gait Training		Back Program
	Cervical/Pelvic Traction		Posture/Body Mechanics		Hip Program
	Heat/Cryotherapy		Neck and Back Stabilization		Knee Program
	Manual Therapy		Relaxation		Ankle/Foot Program
	Joint Mobilization		Home Exercise Program		
	Myofascial Release		**Testing**		**Medical Supplies/Other**
	Manual Traction		Functional Work Assessment		

Physician Signature _____ Date _____
Physician Name _____ Phone _____
Address _____ Fax _____

725 Kapiolani Blvd, Suite C202, Honolulu, HI 96813 Phone 596-7200 Fax 596-0097
Milton S. Kurashige, PT. **Harvey M. Nakamoto, PT.**