Lim
physical therapy

1598 Ulupii St. Kailua, HI 96734
Ph: 808-234-4897 Fax: 888-509-9789
LimPhysicalTherapy@gmail.com
www.LimPhysicalTherapy.com

Patient Name_____ DOB_____

Physician_____ Follow up Date_____

Diagnosis_____

Precautions/Comments_____

_____

_____

_____

□ Evaluate and Treat

□ At Therapist's discretion

□ Strength / ROM

□ Core Strengthening

□ Modalities

□ Manual Therapy

□ Functional Training

□ Balance / Gait

□ Neuro Re-ed

Frequency/Duration _____ times per week for _____ weeks.

I hereby certify these services as medically necessary for this patient's plan of care.

Physician Signature _____ Date_____