WAILUKU PHYSICAL THERAPY
Queen Ka'ahumanu Center Executive Building
285 W Ka'ahumanu Ave, Suite 205, Kahului, Hawaii 96732
Phone 808-877-4663 Fax 808-877-4662

PAIA PHYSICAL THERAPY
149 Hana Highway, Suite 6
Paia, Hawaii 96779
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Treatment Plan and Prescription

Patient Name ____________________ Phone ____________ Date ________

Diagnosis ____________________ ICD-10 Code ____________ D.O.B. ________

Is patient aware of diagnosis and prognosis? Yes ____ No ____ D.O.I. ________

Physician ____________________ Work Comp ________ No Fault ________

Insurance Carrier ____________________ Claim # ____________________

❑ **Evaluate and Initiate Treatment as indicated (including re-evaluations)**

Treatment Goals and Objectives

- ❑ Improve body mechanics / posture
- ❑ Decrease Pain
- ❑ Improve general fitness
- ❑ Home exercise program (HEP)
- ❑ Increase ROM
- ❑ Increase strength
- ❑ Improve function
- ❑ Maximum ambulatory ability
- ❑ Improve balance
- ❑ Improve ADL independence
- ❑ Decrease and prevent falls
- ❑ Increase joint mobility

Modalities / Procedures

- ❑ Spine stabilization / Body Mechanics / Posture
- ❑ Gait / Balance / Assistive device training
- ❑ ROM ~ passive, active-assistive, active
- ❑ Therapeutic Exercise / Functional strength training
- ❑ Manual therapy ~ Joint and soft tissue mobilization
- ❑ Neuromuscular re-education
- ❑ Traction ~ mechanical, manual, home set-up
- ❑ Thermal modalities ~ heat, ice, ultrasound, laser
- ❑ Iontophoresis / Phonophoresis
- ❑ Pilates and therapeutic yoga
- ❑ Vestibular rehabilitation

Special Programs:

- ❑ Wellness Program
- ❑ **Aquatic Therapy Program**
- ❑ Fall Prevention Program
- ❑ Occupational Rehabilitation Program
  - ❑ Current work status ❑ off work ❑ light duty
    - ❑ restricted hours ______/day ______/week
- ❑ Workplace Ergonomic Assessment

Specific Protocols:

- ❑ Post-Surgical Protocol: Date of Surgery ____________

Procedure ____________________

Other Specific Instructions / Precautions:

____

____

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❑ Occupational Therapy Frequency (times/week)________ Duration (weeks)________ Total Visits________

❑ Massage Therapy Frequency (times/week) ________ Duration (weeks) ________ Total Visits________

Frequency (times / week) ____________ **Duration (weeks)** ____________ **Total Visits**____________

I certify the services furnished under this plan of treatment are reasonable and necessary.

Physician's Signature____________________ **Date** ____________

Start Date ____________ Proj. Termination Date ____________ Estimated Cost ____________

The above treatment plan is ❑ Approved ❑ Denied Adjuster's Name ____________________

Adjuster's Signature____________________ Date____________

Therapist's Signature ____________________ Date____________

Orthopaedics . Seniors . Work & Auto Injuries . Back & Neck Injuries . Athletes . Massage Therapy . Pilates . Yoga . Aquatics