PHYSICAL THERAPY ASSOCIATES, L.L.C

PRESCRIPTION

Patient's Name:		Insurance Co:
Phone (H):	(W):	
Date of Injury:		Adjuster:
Employer:		Claim #:

Frequency & Duration: x per week for weeks	Dates of Service: Start: End:

Diagnosis:	ICD-9:

DATE / TYPE OF SURGERY:

☐ **EVALUATE AND TREAT** ☐ **Continue with Current Rehabilitation Program**

PHYSICAL REHABILITATION	**PROCEDURES**	**MODALITIES**
☐ Progressive Resistive Exercises	☐ ROM	☐ Hot Packs
☐ Work Reconditioning	☐ Active	☐ Cold Packs
☐ Spinal Stabilization	☐ Passive	☐ Electrical Stimulation
☐ Upper Quarter Program	☐ Soft Tissue Mobilization	☐ Ultrasound
☐ Lower Quarter Program	☐ Joint Mobilization	☐ Traction
☐ Post-Operative Program:	☐ Manual Traction	☐ Cervical
_____	☐ Gait Training	☐ Lumbar

GOALS AND MEASUREABLE OBJECTIVES

DECREASE:	**INCREASE:**	**EDUCATE:**
☐ Pain	☐ ROM / Flexibility / Mobility	☐ Home Exercise Program
☐ Effusion	☐ Strength / Stability	☐ Postural Awareness
☐ Movement Dysfunction	☐ Conditioning / Endurance	☐ Lifting / Carrying Mechanics
☐ _____	☐ _____	☐ Appropriate Footwear
		☐ _____

Special Instructions_____

Physician's Signature _____ Date_____

Physician Name:	Phone:
Address:	Fax:

(SEE MAP ON BACK)

770 KAPIOLANI BLVD
SUITE 104
HONOLULU, HI 96813
Ph: 596-9446 Fax: 596-9160

94-547 UKEE ST
#100
WAIPAHU, HI 96797
Ph: 596-9446 Fax: 596-9160