

**FOR REHAB USE ONLY**

Scheduled: \_\_\_\_\_  
Service: \_\_\_\_\_  
Program: \_\_\_\_\_

**TREATMENT PLAN & PRESCRIPTION**

**Nuuanu** Fax: 535-2018  
Phone: 544-3310

**Aiea** Fax: 535-2040  
Phone: 486-8000

**Hilo** Fax: 961-6473  
Phone: 961-5776

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Tertiary Insurance: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Onset Date Illness/Injury/Accident: \_\_\_\_\_ Surgery Date: \_\_\_\_\_

ICD-10: \_\_\_\_\_ Precautions: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**PHYSICAL THERAPY EVALUATE & TREAT**  
Frequency/Duration \_\_\_\_\_

**SPEECH/COGNITIVE THERAPY EVALUATE & TREAT**  
Frequency/Duration \_\_\_\_\_

**OCCUPATIONAL THERAPY EVALUATE & TREAT**  
Frequency/Duration \_\_\_\_\_

Dysphagia Eval & Treat     Modified Barium Swallow  
 Speech/Cognitive Treatment

**HAND THERAPY EVALUATE & TREAT**  
Frequency/Duration \_\_\_\_\_

MODALITIES	THERAPEUTIC PROCEDURE	RETURN TO WORK	OTHER SERVICES
<input type="checkbox"/> Thermal Agents <input type="checkbox"/> Ultrasound <input type="checkbox"/> Electric Stim <input type="checkbox"/> Traction <input type="checkbox"/> Paraffin -Dexamethasone -Other _____ <input type="checkbox"/> Fluidotherapy	<input type="checkbox"/> Therapeutic Exercise/Activities <input type="checkbox"/> Manual Therapy <input type="checkbox"/> Joint Mobilization <input type="checkbox"/> Soft Tissue Mobilization <input type="checkbox"/> Myofascial Release <input type="checkbox"/> Gait Training <input type="checkbox"/> Neuromuscular Reeducation <input type="checkbox"/> ADL Training <input type="checkbox"/> Development of Cognitive Skills	<p style="text-align: center;">HILO ONLY</p> <input type="checkbox"/> Functional Capacity Evaluation (Up to 5 hours) <input type="checkbox"/> Work Hardening Evaluation (1 hr) and Treatment (1-4 hrs) <input type="checkbox"/> Job Site Evaluation <input type="checkbox"/> Work Transition	<input type="checkbox"/> Orthotic/Prosthetic Fitting, Training, and/or Fabrication <input type="checkbox"/> Aquatic Therapy* <input type="checkbox"/> Drivers Evaluation/Training* <input type="checkbox"/> Wheelchair Evaluation* (Physical Performance Test) <input type="checkbox"/> Wheelchair Management Training <input type="checkbox"/> Vestibular Rehabilitation <input type="checkbox"/> Lymphedema Management** <input type="checkbox"/> Incontinence Management**  * Nuuanu Only ** Nuuanu/Hilo Only

Other: \_\_\_\_\_

Case Manager (CMRN): \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ Fax/Phone: \_\_\_\_\_

**Physician Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

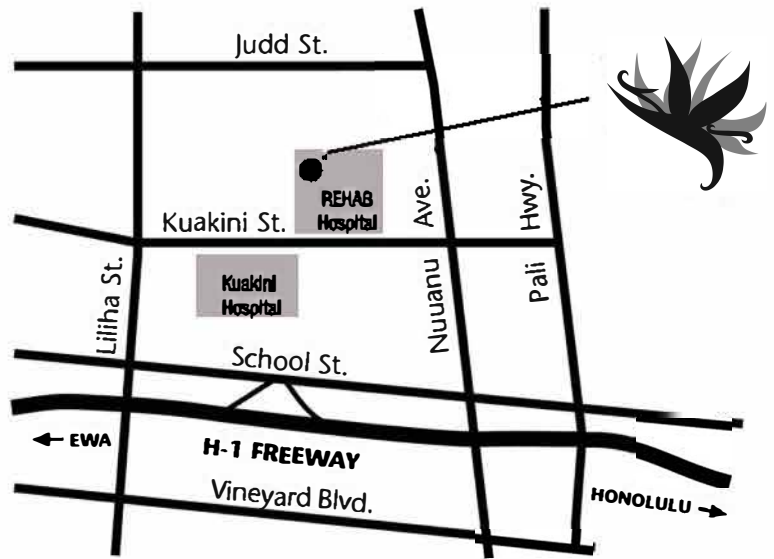
FOR WORK COMP ONLY: Estimated Cost: \_\_\_\_\_ (estimated by treating therapist)

# OUTPATIENT SERVICES

## REHAB at Nuuanu

226 North Kuakini Street  
Honolulu, Hawaii 96817

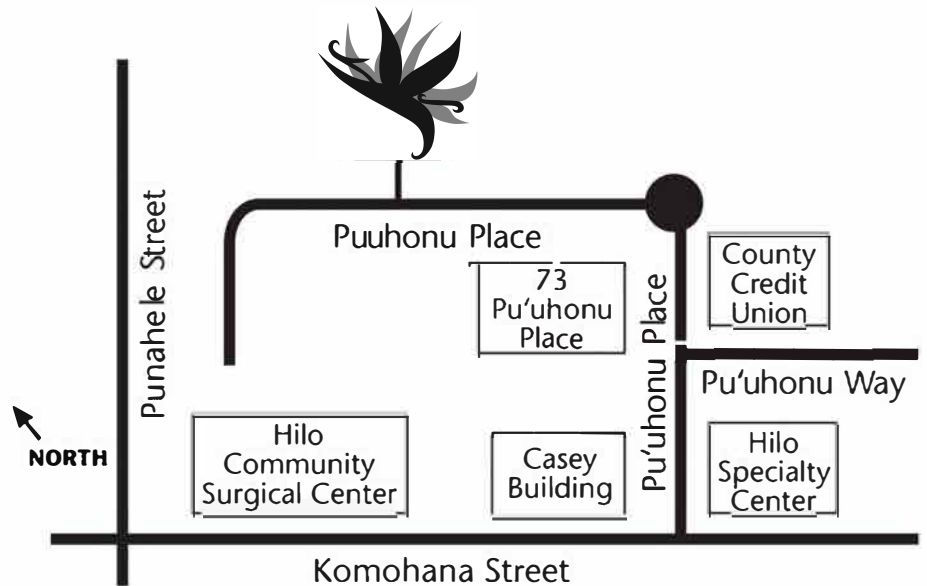
Ph: (808) 544-3310  
Fax: (808) 535-2018



## REHAB at Hilo

76 Puuhonu Place  
Hilo, Hawaii 96720

Ph: (808) 961-5776  
Fax: (808) 961-6473  
Toll Free: 1-800-973-4229



## REHAB at Aiea

98-1005 Moanalua Road, Suite 425  
Pearlridge Center - Pearlridge Downtown  
Aiea, Hawaii 96701

Ph: (808) 486-8000  
Fax: (808) 535-2040

