PHYSICAL THERAPY

Bodies in Motion

1325 S. Kihei Rd. Suite 110 Kihei, HI 96753 808.874.6972 Fax 808.874.6973

TREATMENT PLAN & PRESCRIPTION

☐ Worker's Compensation ☐ No-Fault ☐ Insurance Carrier: _____

Patient Name _____ Date of Injury _____

Diagnosis _____

Phone # _____ DOB _____ Date of Surgery _____

Specific Instructions/Precautions _____

Physical Therapy Evaluation and Treat

Frequency & Duration _____ ***/ week x*** _____ ***weeks*** ***Total Treatments*** _____

☐ Therapeutic Exercise

☐ Modalities:

___ *Electrical Stimulation*

___ *Ultrasound*

___ *Mechanical Traction*

___ *Heat/Cold*

☐ Manual Therapy

☐ Aquatic Therapy

☐ Gait Training

☐ Home Exercise Program

☐ Other _____

☐ Improve body mechanics/posture

☐ Decrease pain

☐ Increase ROM

☐ Increase strength

☐ Improve function

☐ Improve ambulatory ability

☐ Balance training

X Physician Name _____ **X** Physician Signature _____ Date _____

X Therapist Signature _____ Date _____

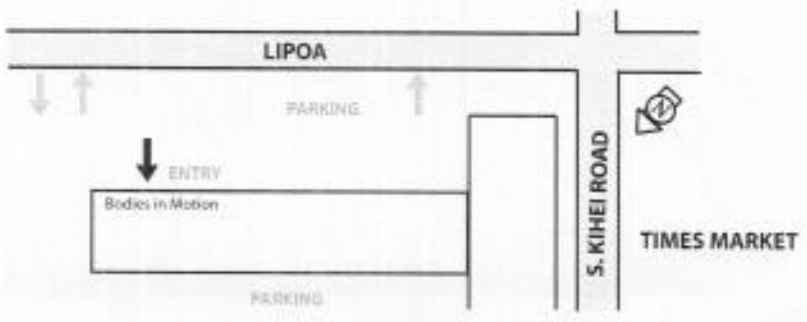
Worker's Compensation Only

Case Manager (CMRN) _____ Phone/Fax _____

Adjuster _____ Phone/Fax _____

Claim # _____

Approved: ___ Yes ___ No



REV-3.14.16