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|  | **Mililani Physical Therapy, LLC**  **95-720 Lanikuhana Ave, #140**  **Mililani, Hawaii 96789**  **Phone: 623-6244 Fax: 623-6414** | |  |
| Vanessa Dasalla, PT, DPT  Lita Endaya, PT  Lynne Estabilio, PT  Tammie Harada, PT  Jessica Johnson, PT, DPT | | Jaymee Kau, PT DPT  Mary Lau-Miki, PT, DPT  Mark Miki, PT, DPT, OCS, CSCS  Jinky Nisperos, PT, DPT  Sheyenne Turk, PT, DPT | Ruby Jones, LMT  Kimiko Miyake, LMT  Ivy Rivera, LMT  Nelson Yoshida, LMT  Devyn Brubaker, LMT |

**Physical Therapy Prescription / Treatment Plan**

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| Patient’s Name: | |  | |  | Phone: |  | | | |
| Type of Insurance:  Work Comp  No Fault  Medicare  HMSA Other | | | | | | | | |  |
| Insurance Company: | | |  |  | Claim#: |  | | | |
| Referring Physician: | | |  |  | Phone: |  | | | |
| Diagnosis: |  | | |  | Date of Injury: | |  | | |
| Special Instructions: | | |  |  | Date of Surgery: | | |  | |

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| **Physical Therapy Evaluation and Treatment** | **Massage Therapy** |
| **Mobile Physical Therapy** | **Home Program** |

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| **Modalities:** | | | **Procedures:** | **Specialized Programs:** |
| Moist Heat / Cold | | | **Manual Therapy**: | Neck |
| Iontophoresis | | | Cervical / Lumbar Traction | Back |
| Ultrasound | | | Joint Mobilization | Shoulder |
| TENS | | | Spinal Mobilization | Elbow |
| Electrical Stimulation | | | Manual Lymph Drainage | Wrist/hand |
| Biofeedback | | | Myofascial Release | Hip |
|  | | | Soft Tissue Mobilization | Knee |
|  | | | Massage | Ankle/Foot |
|  | | | Myotherapy | Vestibular Rehab |
| **Equipment / Supplies:** | | | **Therapeutic Exercises**: | Stroke Rehab |
| Please list: | | | Range of Motion | Gait Training |
|  |  |  | Active / Passive | Osteoporosis |
|  |  |  | Stretching | Incontinence |
|  |  |  | Stabilization | Post-Surgical Breast Program |
|  | | | Strength/Conditioning | Lymphedema |
|  | | | Resistive Exercise | Pelvic Floor Rehab |
|  | | |  | Other: |

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| Measurable Objectives / Goals: | | Please refer to enclosed report | | | | |
| Frequency:  daily  1x/week  2x/week  3x/week | | | | | | |
| Duration: \_\_\_\_\_  weeks /  months. | | | | | | |
| Number of sessions: |  | | Cost Estimate: | ­­per insurance fee schedule | | |
| Estimated date of termination: |  | | Period to Cover: |  | ­to |  |

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| --- | --- | --- |
| Physician’s Signature |  | Date |