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Physical Therapy Prescription / Treatment Plan

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

- Physical Therapy Evaluation and Treatment Massage Therapy
 Mobile Physical Therapy Home Program

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

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 _____

Physician's Signature

Date