



**PT Hawaii-Waipahu**  
**Waipahu Professional Center**  
**94-801 Farrington Hwy, Waipahu, HI 96797**  
**Phone: (808)680-9123 • Fax: (808)680-9889**

- Workers Compensation \_\_\_\_\_
- Employer \_\_\_\_\_
- No Fault (Auto) \_\_\_\_\_
- Private \_\_\_\_\_
- Medicare \_\_\_\_\_

## Rehabilitation Referral and Treatment Plan

Patient Name: \_\_\_\_\_ Diagnosis/ICD-9 code \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work) \_\_\_\_\_  
 Date of Injury/Surgery: \_\_\_\_\_

- EVALUATE AND TREAT**
- PHYSICAL THERAPY**
  - Therapeutic Exercises**  
HEP, postural education/ergonomics
  - Modalities**  
Mechanical traction, electrical stimulation, ultrasound, heat & cold
  - Manual Therapy**  
Joint mobilization, manual traction, myofascial release, Strain-counterstrain
  - VESTIBULAR/NEUROMUSCULAR REHAB**  
Canalith repositioning, balance/gait training, vertigo, functional re-training.
  - STRAPPING**  
McConnell, K-tape, Sports Tape, Leukotape
- WORK CONDITIONING:** (3 days/week) 2 Hour treatment will include strengthening and conditioning, initiating specific job simulation activities.
- AQUACARE**  
Aquatic Therapy in a 100,000 gallon chlorinated salt water (solar heated) pool. Utilizing specifically designed activities to aid in the restoration, maintenance, and quality of function for patients with acute or chronic disabilities.
- MASSAGE THERAPY**  
Myofascial release, Triggerpoint release, and more.
- PRECAUTIONS/SPECIAL INSTRUCTIONS**  
Operation report  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEASUREABLE GOALS/OBJECTIVES

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <b>Decrease:</b>                              | <b>Increase:</b>                      | <b>Increase:</b>                             | <b>Educate:</b>                                |
| <input type="checkbox"/> Tenderness/Tightness | <input type="checkbox"/> Endurance    | <input type="checkbox"/> Functional Activity | <input type="checkbox"/> Home Exercise Program |
| <input type="checkbox"/> Swelling             | <input type="checkbox"/> ROM/Mobility | Tolerance                                    | <input type="checkbox"/> Body Mechanics/ADL's  |
| <input type="checkbox"/> Pain                 |                                       | <input type="checkbox"/> Strength/Stability  | <input type="checkbox"/> Symptom Management    |
| _____ fr _____ to _____                       | _____ fr _____ to _____               | _____ fr _____ to _____                      |  |
|   | _____ fr _____ to _____               | _____ fr _____ to _____                      |  |

Treatment Frequency \_\_\_\_\_ visits/week for \_\_\_\_\_ weeks. Total Visits: \_\_\_\_\_

Estimated Treatment dates \_\_\_\_\_ to \_\_\_\_\_ Estimated cost \$ \_\_\_\_\_

Adjuster (print) \_\_\_\_\_ Signature \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Claim No. \_\_\_\_\_  Approved  Denied

**Physician Name (print):** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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***Home of the  
AquaCare™  
Program***