



HANDS-ON Physical Therapy

Orthopedics, Sports-Injuries & Women's Health

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PHYSICAL THERAPY PRESCRIPTION

Name

DOB

Diagnosis / ICD-9 code

Date of onset/ surgery

Insurance of patient:

Frequency & Durationtimes per week for.....weeks

EVALUATE & TREAT

CONTINUATION OF PT

MODALITIES	MANUAL THERAPY	THERAPEUTIC EXERCISE & REHABILITATION
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Specific joint mobilization	<input type="checkbox"/> Pelvic floor program
<input type="checkbox"/> Electrical stimulation	<input type="checkbox"/> Myofascial release/ Stretch	<input type="checkbox"/> Stabilization program
<input type="checkbox"/> Hot / Cold packs	<input type="checkbox"/> Cervical Spine mobilization	<input type="checkbox"/> ROM (active, active assisted, passive)
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Lumbar/Thoracic spine mobilization	<input type="checkbox"/> Relaxation training
<input type="checkbox"/> Dilators	<input type="checkbox"/> Sacro-iliac joint treatment	<input type="checkbox"/> Behavioral training
<input type="checkbox"/> Home Tens unit	<input type="checkbox"/> Strain/ counterstrain	<input type="checkbox"/> Home exercise program
<input type="checkbox"/> Traction (Cx/Lx)	<input type="checkbox"/> Visceral mobilization/Muscle Energy	<input type="checkbox"/> Video Analysis and Feedback
<input type="checkbox"/> Other Please specify:	<input type="checkbox"/> TMJ / Headache / Sinus treatment	<input type="checkbox"/> Customized Orthotics
.....	<input type="checkbox"/> Other.....	<input type="checkbox"/> Other

Special Instructions / Recommendations:

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Date Physician Signature

Please provide patient's telephone number(s) for scheduling

