Hana Lima Physical Therapy

Ph: 808-446-0382
Fax: 808-876-0245
HanaLimaPT.com
HanaLimaPT@gmail.com

Patient Name: _____ DOB: _____

Home Phone #: _____ Other Phone #: _____

ICD-10 (Diagnosis): _____

☐ Insurance: _____ Policy #: _____

☐ MVA / No-Fault:

Company: _____ Claim #: _____

Adjuster & Phone #: _____

☐ Work Comp: Company: _____ Claim #: _____

Adjuster & Phone #: _____

Frequency of Treatment: ☐ Standard Plan: 1-2 days/week x 4-6 weeks

☐ Modified Plan: _____ days/week x _____ weeks

☐ **Physical Therapy: Evaluate & Treat as appropriate**

☐ **Occupational Therapy: Evaluate & Treat as appropriate**

☐ **Massage Therapy** ☐ Lymphatic Drainage

☐ Post-Op Protocol ☐ Vestibular Rehabilitation

☐ Workplace Ergonomic Assessment ☐ Modalities prn

Physician Notes: _____

_____

_____

I hereby certify that Physical and/or Occupational Therapy is medically necessary for this patient's Plan of Care.

Physician Name: _____

_____

Signature Date

Please fax this referral to 808-876-0245. Mahalo!