HANA LIMA PHYSICAL THERAPY

PH: 808-446-0382
FAX: 833-520-1530
HANALIMAPT@GMAIL.COM
HANALIMAPT.COM

PATIENT: _____ DOB: _____

PHONE #: _____ ALT PHONE #: _____

ICD-10 (DIAGNOSIS): _____

☐ INSURANCE & POLICY #: _____

☐ MVA / NO-FAULT / 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

☐ **EVALUATE & TREAT AS APPROPRIATE**

☐ POST-OP PROTOCOL
☐ MODALITIES PRN
☐ VESTIBULAR REHABILITATION
☐ LYMPHATIC DRAINAGE

PHYSICIAN NOTES: _____

_____

_____

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

PHYSICIAN NAME: _____

_____
SIGNATURE DATE

PLEASE FAX THIS REFERRAL TO 833-520-1530. MAHALO!