NORTH HAWAII COMMUNITY HOSPITAL

Rehabilitation Services
67-1125 Mamalahoa Hwy, Kamuela, HI 96743 *p* 808.881.4860 *f* 808.881.4862

REHAB SERVICES REFERRAL/PRESCRIPTION

☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Speech Therapy** ☐ **Massage Therapy**

Patient Name_____ Birthdate_____ Tel #_____

Insurance: ☐ Workers Comp ☐ No Fault ☐ HMSA ☐ Medicare ☐ Quest
☐ Aloha Care ☐ Ohana Health ☐ EverCare ☐ Other_____

ICD-9 CODE(S)_____Date of Injury/Onset_____

Diagnosis_____

Surgical Procedures_____Date of Surgery_____

☐ Evaluate & Treat_____ times per week for _____weeks OR a total of _____ visits.

☐ Precautions/WEIGHT BEARING STATUS:_____

TREATMENT GOALS

☐ **Per Therapist** ☐ **Per Physician as Indicated Below:**

DECREASE	INCREASE	EDUCATE
☐ Swelling (_____)	☐ ROM/Mobility (_____deg.)	☐ Home Ex. Program
☐ Pain (Level_____)	☐ Strength/Stability	☐ Posture
☐ Dysfunction	☐ Functional Capacity	☐ Body Mechanics/ADLs
☐ Sensation	☐ Return to Work	☐ Edema Control/Pain Mngmt
☐ Risk of Aspiration (ST)	☐ Sensation	☐ Joint Protection
☐ Vocal Abuse (ST)	☐ Speech Intelligibility/Vocal Quality (ST)	☐ Energy Conservation
☐ Fall Risk/Balance	☐ Expression (ST)	☐ Splint Wearing/Maintenance
☐ Other_____	☐ Cognition (ST)	☐ Work Modification
_____		☐ Caregivers on Feeding (ST)
_____		☐ Compensatory Strategies (ST)

TREATMENT MODALITIES/PROCEDURES

☐ **Per Therapist** ☐ **Per Physician as Indicated Below:**

☐ Ultrasound	☐ Mobilization (joint/soft tissue)	☐ Gait Training
☐ Hot/Cold Packs	☐ Neuromuscular Re-ed	☐ Adaptive Equipment Training
☐ Paraffin Bath (OT)	☐ T.E.N.S. (home/clinic)	☐ ADL Re-training
☐ Kinesiotaping	☐ E-Stim (home/clinic)	☐ Hand Rehab
☐ Pre-op Teaching/Training _____	☐ Iontophoresis	☐ Splint Fab (_____)
☐ Work Hardening/Return to Work	☐ Phonophoresis with Hydrocortizone	☐ Edema Control/Pain Mngmt
☐ Functional Capacity Eval (FCE)	☐ Therapeutic Exercise/HEP	☐ Scar Management
☐ Traction	☐ Therapeutic Activity	☐ Desensitization/Sens Re-ed

SPEECH THERAPY EVALUATION

☐ **Swallow Eval: Clinical/Video Swallow** ☐ **Speech/Voice Pathology** ☐ **Language/Cognition** ☐ **Other**

PHYSICIAN's SIGNATURE_____

Physicians Name (print)_____ Date_____