MOLOKAI PHYSICAL THERAPY & REHABILITATION LLC

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PHYSICAL THERAPY PRESCRIPTION

Patient's Name _____

DOB: _____ Phone: _____ eMail: _____

Date of injury/illness: _____Surgery date: _____

Diagnosis #1: _____ ICD-10: _____

Diagnosis #2: _____ ICD-10: _____

History/Precautions: _____

Goals and Measurable Objectives: _____

☐ Physical Therapy Eval & Treat

Frequency: ____ x wks

Duration ___ wks

Special Instructions: _____
_____
_____
_____

Follow-up Date Referring Provider: _____

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

Physician's Signature: _____ Date _____

Physician's Name: _____ Phone: _____ Fax: _____

For office use only

Treatment Start Date:_____ Treatment End date:_____

Authorization: _____