MAKAI MOBILE REHAB

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Physical Therapy Prescription

Name:_____ **DOB:**_____

Patient Phone Number:_____**DOS:**_____

Diagnosis / ICD-9 :_____

Primary Insurance:_____ **Secondary:**_____

☐ **Evaluate and Treat**

Services:

- ☐ **Therapuetic Exercise**
- ☐ **Balance**
- ☐ **Gait Training**
- ☐ **AROM / PROM**
- ☐ **other**_____
- ☐ **Soft Tissue Massage**
- ☐ **Jt. Mobilization**
- ☐ **Manual Traction**
- ☐ **Electric Stimulation**

Frequency: _____ **x week /** _____ **weeks**

Special Instructions/Precautions/Treatment Goals:_____

_____

_____

I do hereby certify that it is a medical necessity this patient receives rehabilitation services as an **in-home outpatient physical therapy patient**.

Physician Signature:_____ **Date:**_____

Please fax prescription to (808) 396-5581

Thank You for this referral!