CORE Sports
Physical Therapy & Orthopedic Rehabilitation

☐ KAPOLEI CLINIC
599 FARRINGTON HIGHWAY, SUITE 102
KAPOLEI, HI 96707

☐ HONOLULU CLINIC
725 KAPIOLANI BOULEVARD, SUITE 103C
HONOLULU, HI 96813

PHONE: (808) 674-1142 FAX: (808) 674-1143

☐ Private Insurance: _____
☐ No Fault (Auto) _____
☐ Worker's Compensation: _____ Employer_____

REHABILITATION REFERRAL AND TREATMENT PLAN

Patient's Name:	**Date of Birth:**
Contact Number:	**Date of Injury/Surgery:**
ICD-10s	
Diagnoses:	

☐ MASSAGE THERAPY	☐ PHYSICAL THERAPY Evaluate and Treat	
_____ x per week for _____weeks. TOTAL_____ (Worker's Compensation, No Fault Insurance, Cash Pay) (Therapeutic, Sports, Trigger point/Shiatsu, Pre/Post-Natal, Swedish, Deep tissue)	_____ x per week for _____weeks. TOTAL_____	
☐ Work Conditioning	☐ Manual Therapy	
_____ x per week for _____weeks. TOTAL_____ (2-3 days/week for up to 2 hours of strength and conditioning specifically for initial steps to return to work for specific duties)		Myofascial Release, soft-tissue mobilizations, manual traction, strain-counterstrain, GRASTON
☐ Work-Hardening	☐ Therapeutic Exercises	
_____ x per week for _____weeks. TOTAL_____ (3-5 days/week up to 4 hours of strength, conditioning, and work endurance to meet demands of full duty work, including patient education, safety, ergonomics)		Individualized Home Exercise Program (HEP), Postural education, ergonomics, targeted and functional strength and stabilization
MEASURABLE GOALS	☐ Neuromuscular Re-Education	
○ Decrease Pain from_____to____ ○ Increase ROM from_____to_____ ○ Increase Strength from _____to____ ○ Other:		Advanced gait training, balance, coordination, and Proprioceptive Neuromuscular Re-education (PNF)
	☐ Strapping/Taping	
PRECAUTIONS/SPECIAL INSTRUCTIONS		Mulligan and McConnell techniques Leukotape, Kinesiotape, Rocktape Available options for pre-performance taping, patient tutorials, and home kits
	☐ Modalities	
		electrical stimulation, ultrasound,

Physician Signature_____Date:_____

Physician's Name (printed)_____ Phone: _____Fax: _____

For Office Use Only

Treatment Plan Dates:			**Estimated Cost:**
Adjustor's Name:		**Signature:**	
Claim Number:		**Phone:**	**Fax:**
☐ Approved	☐ Denied	**Date of Action:**	