PIRCO
PHYSICAL & INDUSTRIAL REHABILITATION CLINIC OF OAHU LLC

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PRESCRIPTION FOR REHABILITATION

CLIENT: _____ PHONE NUMBER: _____

PHYSICAN / DOCTOR: _____ PHONE NUMBER: _____

DIAGNOSIS / ICD10: _____ DATE OF ONSET / INJURY: _____

INSURANCE / CLAIM NO.: _____ EMPLOYER: _____

ADJUSTER: _____ PHONE NUMBER: _____ FAX: _____

CASE MANAGER: _____ PHONE NUMBER: _____ FAX: _____

☐ **MASSGE THERAPY**: FREQUENCY: _____ DAYS / WEEK DURATION: _____ WEEKS

☐ OTHER / COMMENTS: _____

_____

☐ **PHYSICAL THERAPY**: FREQUENCY: _____ DAYS / WEEK DURATION: _____ WEEKS

PROCEDURES: ☐ EVALUATE & TREAT ☐ BACK PROGRAM ☐ NECK PROGRAM ☐ EXTREMITY PROGRAM

☐ SPECIAL INSTRUCTIONS / PRECAUTIONS: _____

_____

☐ OTHER COMMENTS: _____

_____

☐ **INDUSTRIAL REHABILITATION:** FREQUENCY: _____ DAYS / WEEK DURATION: _____ WEEKS

EVALUATION: ☐ FUNCTIONAL CAPACITIES EVALUATION (**FCE**) ☐ JOB ANALYSIS ☐ JOBSITE EVALUATION

PROCEDURES: ☐ WORK CONDITIONING PROGRAM (2 HOURS) ☐ WORK HARDENING PROGRAM (3-4+ HOURS)

☐ OTHER / COMMENTS: _____

_____

_____

PHYSICIAN / DOCTOR SIGNATURE: _____ DATE: _____

(I CERTIFY THAT THE ABOVE SERVICES ARE MEDICALLY NECESSARY)

ADJUSTER/ CASE MANAGER SIGNATURE: _____ **APPROVED**_____ DENIED_____

Comments: _____

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