PIRCO
Physical & Industrial Rehabilitation Clinic of Oahu LLC

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PRESCRIPTION

Client Name _____ DOB _____

Phone Number _____ Date of Injury/Surgery _____

ICD 10 _____ Diagnosis _____

ICD 10 _____ Diagnosis _____

Insurance _____ Claim # _____ Employer _____

Adjuster _____ Phone # _____ Fax # _____

Case Manager _____ Phone # _____ Fax # _____

☐ **PHYSICAL THERAPY** - Evaluate & Treat: _____ Days/Week for _____ Weeks

☐ **MASSAGE THERAPY**: _____ Days/Week for _____ Weeks

☐ **WORK CONDITIONING PROGRAM** (2 hours): _____ Days/Week for _____ Weeks

☐ **WORK HARDENING PROGRAM** (3-4 hours): _____ Days/Week for _____ Weeks

☐ **FUNCTIONAL CAPACITY EVALUATION**: _____ General _____ Job Specific

Other Comments: _____

Physician Signature: _____ Date: _____
(I certify that the above services are medically necessary)

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

Adjuster/Case Manager Signature: _____ Approved ____ Denied ____

Comments: _____