

South Kona Physical Therapy Referral



Outpatient Physical Therapy
82-6066 Mamalahoa Hwy., Suite #7
Captain Cook, HI 96704
Phone: (808) 323-8123 Fax: (808) 323-8125
Website: southkonapt.com

Date: _____

Patient Name: _____ Patient DOB: _____

Patient Telephone #: (_____) _____ - _____

Primary Insurance: _____

Diagnoses/ICD-9: _____

Special Instructions/Precautions: _____

Frequency of visits: _____ times per week for _____ weeks.

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Evaluate & Treat

Protocol Attached

Modalities

- Ultrasound
- Low Level Laser/Cold Laser
- Electrical Stimulation
- Hot/Cold Packs
- Traction (Cervical/Pelvic)
- Paraffin
- Phonophoresis
- Biofeedback
- T.E.N.S. (Instruct/Loan)

Procedures

- Soft Tissue Mobilization
- Joint Mobilization
- Manual Stretching
- Myofascial Release
- Neuromuscular Re-Education
- Gait Training
- Lymphedema Treatment

Therapeutic Exercises

- Active ROM
- Passive ROM
- Active Strengthening
- Lumbar Stabilization
- Pilates
- Plyometrics
- Directed Gym Program
- Independent Gym Program

Industrial Rehabilitation

- Work Hardening/Conditioning
- Back School
- Body Mechanic Training
- Functional Capacity Eval. (FCE)

Vestibular Techniques

- Balance/Vertigo (Ear/Brain Conditions)
- Proprioceptive Training
- BPPV Assessment (Epleys)
- BPPV Treatment

Therapeutic/Sport Taping

- McConnell Taping
- Kinesio/Rock Taping
- Taping Supplies

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I CERTIFY THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY AND IS APPROVED.

Physician Signature: _____ **Date:** _____

(This must be signed by Doctor in order for your insurance to be billed.)

Thank you for your referral!