Hawaii Physical Therapy & Chiropractic Clinic, Inc.

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REFERRAL FORM	Patient:	Birth Date:
	Date of Onset/Injury:	Employer:
Home Phone:	Work Phone:	Cell Phone:

INSURANCE COVERAGE:

❑ Akamai Advantage ❑ Blue Cross/Blue Shield ❑ HMAA
❑ HMSA ❑ HMSA Quest ❑ Medicare ❑ TriCare/TriWest ❑ UHA
❑ No-Fault ❑ Work Comp ❑ Other:

Name of Insurance Carrier: ________________________ Member/Claim No.: ______________________

DIAGNOSIS:

Description:	
ICD 10 Codes:	

TREATMENT PRESCRIBED:

	Chiropractic Evaluation and Treatment, as deemed appropriate		Chiropractic Continued Treatment
	Physical Therapy Evaluation and Treatment, as deemed appropriate		Physical Therapy Continued Treatment
	Physical Therapy Evaluation and Consultation before treatment		Back and neck Education
	Physical Therapy Evaluation and Report Only		Infant Stimulation
	One (1) Hour Therapeutic Massage Treatment		

FREQUENCY & DURATION:

Times per Week:	Number of Weeks: and/or:	Total Number of Visits:
Starting Date:	Ending Date:	

Treatment and Procedures:	❑ Massage ❑ Mobilization ❑ Manual Traction ❑ Mechanical Traction ❑ Therapeutic Exercise ❑ Home Exercise Program ❑ Self Care Management Training ❑ Cold Modality ❑ Hot Modality ❑ Electrical Stimulation ❑ Laser Therapy ❑ Ultrasound ❑ Gait Training: ❑ Non-weight bearing ❑ Partial weight bearing ❑ Full weight bearing ❑ Assistive Device Evaluation ❑ Orthotic Management and Training ❑ Orthotic Fitting ❑ Iontophoresis with Dexamethasone sodium phosphate 4mg/ml ❑ Other:
Relevant Information:	Radiologic Findings:
	Related Surgeries:
	Medical Conditions:
	Precautions/Limitations:

Signature: ____________________________________ Date: __________________________
(Referring Physician)

Referring Physician: **Physician's Phone:** **Fax:**