VENTURE PHYSICAL THERAPY
PH. 808-633-4480 FAX. 866-465-8155

Date_____/_____/_____

Name _____ **D.O.B** _____

Diagnosis: _____**ICD 9:**_____**Onset Date:**_____

☐ **EVALUATE AND TREAT** ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Where Patient is to be treated: ☐ Home ☐ 101 Kanani Rd Kihei, HI 96753 ☐ 1063 Lower Main St. Wailuku, HI 96793 ☐ Lanai Community Health Center

Frequency / Duration: _____x week _____weeks= _____Total Visits

Address:_____ __City _____Zip_____

Phone (H)_____ (C)_____ **Gender** ☐ Male ☐ Female

Insurance (Primary)_____**Subscriber ID#**_____

Insurance (Secondary)_____ **Subscriber ID#**_____

Workers Compensation

Claim#_____

Insurance Co._____

Employer_____

Phone#_____

Adjustor_____

Phone#_____

Date of Injury_____

PROCEDURES

☐ Therapeutic Exercise
☐ Gait / Balance Training
☐ Manual Therapy
☐ Joint Mob/Soft Tissue Mob
☐ PROM / AAROM /AROM
☐ Cervical Stability Program
☐ Lumbar Stability Program
☐ Hip/Knee Stability Program
☐ Vestibular Treatment
☐ Orthotic Fitting/Assessment
☐ Wheel Chair Fitting
☐ Sensory Integration
☐ ADL Training
☐ Cognitive Training
☐ Speech Training
☐ Swallow Training
☐ Splinting Finger/Hand
☐ Shoulder Stability
☐ Other_____

MODALITIES

☐ Ultrasound
☐ Electrical Stim
☐ Traction
☐ Moist Heat/Ice
☐ TENS Set up
☐ Iontophoresis
☐ Dexamethasone

Precautions / Instructions: _____

Physician Name (Please Print): _____ Date:_____

Physician Signature: _____ NPI #: _____