**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 #: _____