

Hawaii Physical Therapy & Chiropractic Clinic, Inc.

261 Waiianuenu Avenue ♦ Hilo, Hawai'i 96720

Telephone: (808)961-5663 ♦ Fax: (808)969-3767 ♦ Website: www.hiptchiro.com

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

INSURANCE COVERAGE:

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

Name of Insurance Carrier: _____ Claim No.: _____

DIAGNOSIS:

Description:

ICD 10 Codes:

TREATMENT PRESCRIBED:

<input type="checkbox"/>	Chiropractic Evaluation and Treatment, as deemed appropriate	<input type="checkbox"/>	Chiropractic Continued Treatment
<input type="checkbox"/>	Physical Therapy Evaluation and Treatment, as deemed appropriate	<input type="checkbox"/>	Physical Therapy Continued Treatment
<input type="checkbox"/>	Physical Therapy Evaluation and Consultation before treatment	<input type="checkbox"/>	Back and neck Education
<input type="checkbox"/>	Physical Therapy Evaluation and Report Only	<input type="checkbox"/>	Infant Stimulation
<input type="checkbox"/>	One (1) Hour Therapeutic Massage Treatment		
<input type="checkbox"/>	Purchase:	Cost: \$	

FREQUENCY & DURATION:

Times per Week: _____ Number of Weeks: _____ and/or: _____ Total Number of Visits: _____

Treatment and Procedures:	<input type="checkbox"/> Massage <input type="checkbox"/> Mobilization <input type="checkbox"/> Manual Traction <input type="checkbox"/> Mechanical Traction <input type="checkbox"/> Therapeutic Exercise <input type="checkbox"/> Home Exercise Program <input type="checkbox"/> Self Care Management Training <input type="checkbox"/> Cold Modality <input type="checkbox"/> Hot Modality <input type="checkbox"/> Electrical Stimulation <input type="checkbox"/> Laser Therapy <input type="checkbox"/> Ultrasound <input type="checkbox"/> Gait Training: <input type="checkbox"/> Non-weight bearing <input type="checkbox"/> Partial weight bearing <input type="checkbox"/> Full weight bearing <input type="checkbox"/> Assistive Device Evaluation <input type="checkbox"/> Orthotic Management and Training <input type="checkbox"/> Orthotic Fitting <input type="checkbox"/> Iontophoresis with Dexamethasone sodium phosphate 4mg/ml <input type="checkbox"/> Other:

Relevant Information:	Radiologic Findings:
	Related Surgeries:
	Medical Conditions:
	Precautions/Limitations:

Signature: _____ Date: _____
 (Referring Physician)

Referring Physician: _____ Phone: _____ Fax: _____