Wahiawa Outpatient Rehabilitation

128 Lehua Street 3rd Floor Wahiawa, HI 96786
Office (808) 622-8112 Fax (808) 621-4262

REHABILITATION SERVICES PRESCRIPTION

Patient Name _____ DOB _____ Tel No._____
Address _____
Referring Physician Telephone No. _____ Fax No. _____
Medical Diagnosis & ICD-10 Code _____
Treatment Diagnosis & ICD-10 Code _____
Primary Insurance Carrier _____ **Policy Number**_____
Secondary Insurance Carrier _____**Policy Number**_____
Onset/ Injury Date _____ Frequency/ Duration _____
PRECAUTIONS: _____

□ Physical Therapy – Evaluate & Treat	□ Speech Therapy – Evaluate & Treat □ Speech Language □ Dysphagia □ Modified Barium Swallow Study
□ Occupational Therapy – Evaluate & Treat	

Please include demographics, recent progress notes, radiology result & copy of insurance card

PROVIDER SIGNATURE _____

Provider Name _____ Date _____

Thank you for choosing Wahiawa Outpatient Rehabilitation!

Upon completion of our evaluation, we will promptly fax our Plan of Care (POC).
If approved, please have the Physician print name, sign, and date.
Please fax the POC to our office at your earliest convenience. Mahalo!