☐ **Physical Therapy**
Mackenzie Brown
DPT, OCS, CSCS
810 Kokomo Road
Suite 159
Haiku, HI 96708
P: 808-757-5724
F: 808-442-1421

☐ **Physical Therapy**
Lauren Vander Veen
DPT
810 Kokomo Road
Suite 159
Haiku, HI 96708
P: 808-344-8565
F: 808-575-9109

☐ **Massage Therapy**
Deep Relief // Peak Performance
810 Kokomo Road
Suite 150
Haiku, HI 96708
P: 808-214-8224
F: 808-442-1140

PRESCRIPTION AND TREATMENT PLAN

Patient Name _____ Date of Birth _____ Phone _____

Diagnosis _____ ICD 10 _____

Date of Injury _____ Date of Surgery _____

☐ Work Comp ☐ MVA ☐ Private Insurance ☐ Other

Insurance: _____ Claim Number _____

☑ Please evaluate and initiate treatment as needed (including re-evaluations)

Frequency: _____ times per week Duration: _____weeks Total: _____visits

Specific Treatment Requested:

☐Manual Therapy (Joint/soft tissue mobilization, PROM)
☐Therapeutic Exercise (ROM, stretching, strengthening)
☐Neuromuscular Re-education (core stabilization, postural re-education)
☐Vestibular Rehabilitation
☐Post-concussion Rehabilitation
☐Balance Training
☐Gait Training
☐Modalities (US, E-stim, Laser)
☐Mechanical Traction
☐Sport-Specific Rehabilitation
☐HEP/Gym Program Development
☐ Post-op Protocol
☐ 97124 Massage Therapy
☐Other _____

Precautions/Comments _____

I certify that the services rendered under this prescriptions and plan of treatment are reasonable and necessary.

Physician's Name _____ Date _____

Physician's Signature _____