

# HAWAII WORKERS' COMPENSATION TREATMENT PLAN

TREATMENT COMMENCEMENT DATE:

TREATMENT TERMINATION DATE:

TO (Employer):

Mail:  
Fax:  
Email (At Employer Request):

Patient:  
DOI:                      DOB:                      Ph:  
Claim#:  
Carrier/Insurer:

IMPRESSION OR DIAGNOSIS:

PROGNOSIS:    Poor       Fair       Good       Other:

TREATMENT DESCRIPTION (Modalities and Procedures):

Acupuncture                      Follow Up Office Visit  
Aquatic Therapy                 Massage  
Chronic Pain Management       Occupational Therapy  
Chiro                              Physical Therapy  
Concurrent Care                 Rx Medications  
DME:  
Other:

DIAGNOSTIC DESCRIPTION:

Bone Scan                        CT Scan  
EMG / NCS / CPT                X-ray  
MRI                                Psych Evaluation  
Other:

Referring To:

Address:

Phone:  
Fax / Email:

SPECIFIC TIME SCHEDULE OF MEASURABLE OBJECTIVES AND PROJECTED GOALS BY END OF TREATMENT PLAN:

Decrease pain perception based on 0-10 scale:

<i>Baseline</i>	<i>Goal</i>
area from	to
area from	to
area from	to

Increase active ROM in:

<i>Baseline</i>	<i>Goal</i>
area from	to
area from	to
area from	to

Increase tolerance in hours:

<i>Baseline</i>	<i>Goal</i>
Sitting from	to
Standing from	to
Walking from	to

Increase # of hrs of continuous sleep per night:

<i>Baseline</i>	<i>Goal</i>
	to

Other:

NUMBER AND FREQUENCY:    one time only                      as needed                      x per                      for

TOTAL COST ESTIMATE: \$

Physician Name / Signature

Date

To Be Completed by Individual Reviewing Treatment Plan

Approved        Denied (Denial Reason Below)

Name

Date

Contact Information