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

DIAGNOSTIC DESCRIPTION:

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

☐ **Referring To:** _____ Phone: _____

Address: _____ Fax / Email: _____

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

☐ **Decrease pain perception based on 0-10 scale:**

		Baseline	*Goal*
_____	area from	_____	_____
_____	area from	_____	_____
_____	area from	_____	_____

☐ **Increase active ROM in:**

		Baseline	*Goal*
_____	area from	_____	_____
_____	area from	_____	_____
_____	area from	_____	_____

☐ **Increase tolerance in hours:**

	Baseline	*Goal*
Sitting from	_____	_____
Standing from	_____	_____
Walking from	_____	_____

☐ **Increase # of hrs of continuous sleep per night:**

Baseline	*Goal*
_____	_____

☐ **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