

STATE OF HAWAII
Physical Therapy (PT), Occupational
Therapy (OT) & Speech Therapy (ST)
Report

Please Type

PATIENT NAME (Last, First, M.I.):	BIRTHDATE:	RECIPIENT I.D. NO
Restorative Therapy being considered: <i>(select one discipline per form)</i> <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST		
Primary diagnosis or medical condition for which the therapy is to be provided:		
List applicable secondary diagnosis(es):		
List the 3 main goals of therapy:		
1.		
2.		
3.		
Anticipated period of time therapy is to be provided: <i>(check one)</i>		
<input type="checkbox"/> less than 1 month <i>(indicate # of weeks)</i> <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months		
<input type="checkbox"/> More than 3 months <i>(explain):</i>		
Check ALL that apply:		
<input type="checkbox"/> The patient has received/is receiving restorative therapy. <i>Dates:</i> from _____ to _____		
<input type="checkbox"/> The patient is covered by Medicare and has received/is receiving therapy under the Medicare benefit <i>Dates:</i> from _____ to _____		
<input type="checkbox"/> Patient has completed approved therapy <i>(one or more of the above blocks has been checked)</i> ; additional therapy needed. <i>(explain):</i>		
 <input type="checkbox"/> The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.		
<input type="checkbox"/> The patient is NOT able to participate in therapy a minimum 45 minutes per session. <i>(explain):</i>		
Additional justification for restorative therapy:		
Recommended effective dates of restorative therapy: From _____ To _____		
_____ Signature		_____ Date
Name and Title (TYPE):		
DISPOSITION – DO NOT COMPLETE		
Therapy	Approved?	Effective Dates (TO/FROM)
<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech	[<input type="checkbox"/>] Yes [<input type="checkbox"/>] No	
DHS Reviewer's/Designee's Signature: _____ Date _____		
This form is for use in reporting PT, OT, ST for patients in Nursing Facilities (NFs) and in Acute Hospitals when patients are waitlisted for long term care beds. This form should be completed by the therapist and faxed with the 1147 or 1147a forms and ALL PT/OT/ST assessments previously performed by a facility's therapist(s) when restorative therapy services are being considered. Report one discipline per form.		