STATE OF HAWAII
Department of Human Services
Med-QUEST Division

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

HEALTH SERVICES ADVISORY GROUP, INC.
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Please Print or Type

| PATIENT NAME (Last, First, M.I.): | BIRTHDATE: | RECIPIENT I.D. NO |
|---|---|---|
| | | |

Restorative Therapy being considered: *(select one discipline per form)* ☐ PT ☐ OT ☐ ST

Primary diagnosis or medical condition for which the therapy is to be provided:

List applicable secondary diagnosis(ses):

List the 3 main goals of therapy:

1.
2.
3.

Anticipated period of time therapy is to be provided*: (check one)*

( ) less than 1 month *(indicate # of weeks)* _____ ( ) 1 month ( ) 2 months ( ) 3 months

( ) More than 3 months *(explain):* ____________________

Check ALL that apply:

( ) The patient has received/is receiving restorative therapy. *Dates:* from ____________ to _____________

( ) The patient is covered by Medicare and has received/is receiving therapy under the Medicare benefit *Dates:* from ___________ to ___________

( ) Patient has completed approved therapy *(one or more of the above blocks has been checked);* additional therapy needed. *(explain):*

( ) The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

( ) The patient is NOT able to participate in therapy a minimum 45 minutes per session. (*explain*): ____________________

Additional justification for restorative therapy: ____________________

Recommended effective dates of restorative therapy: From ___________ To ___________

Signature ____________________ Date ____________

Name and Title (PRINT): ____________________

**DISPOSITION – DO NOT COMPLETE**

| **Therapy** | **Approved?** | | **Effective Dates (TO/FROM)** |
|---|---|---|---|
| ☐ PT ☐ OT ☐Speech | [ ] Yes | [ ] 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.