

## STATE OF HAWAII

### Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) Report

<b>Name:</b> _____	<b>Birthdate:</b> _____	<b>Date:</b> _____
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Restorative Therapy(ies) being considered:     PT     OT     ST

Primary diagnosis or medical condition for which the therapy(ies) is/are 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:

- 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 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 is 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 of 45 minutes per session. (*explain*): \_\_\_\_\_

Additional justification for restorative therapy: \_\_\_\_\_

Recommended effective dates of restorative therapy: from \_\_\_\_\_ to \_\_\_\_\_

<b>Print Name and Title</b>	<b>Signature</b>	<b>Date</b>
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<b>Disposition:</b>	<b>To be completed by Med-QUEST division staff or designee</b>
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Restorative     PT     OT     ST     Approved    Effective dates: from \_\_\_\_\_ to \_\_\_\_\_

Not approved

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 done by a facility's therapist(s) when restorative therapy services are being considered.**