Hand and Occupational Therapy

Date: _________________________________ Precautions: _________________________________

Patient Name: _________________________________________________________________ Phone: _________________________________

Diagnosis: _________________________________________________________________ ICD 10 Code: ________ L Code: ________

Date of Injury: __________ Date of Surgery: __________ Procedure: ________________________________

Frequency (Days per week, check one) □ 1 □ 2 □ 3 □ 4 □ 5 for _____ weeks Area to be Treated: ________________________________

☐ Evaluate & Treat  ☐ Treat as indicated below

☐ Therapeutic Exercise
☐ AROM for __________________________
☐ AAROM for __________________________
☐ PROM for __________________________
☐ Joint Mobilizations
☐ Stretching
☐ Manual Therapy
☐ Joint Blocking
☐ Strengthening to begin at ____ wks p-op
☐ Putty Exercises
☐ Tendon Glides
☐ Nerve Glides
☐ Sport Specific Training
☐ Tendon Acceleration
☐ Flexor Tendon Protocol

☐ Custom Orthotic

Type:
☐ Static ☐ volar ☐ dorsal ☐ clamshell
☐ Static Progressive ☐ flexion ☐ extension
☐ Dynamic ☐ flexion ☐ extension

Joint Included:
☐ Digit ☐ DIP ☐PIP ☐ MCP
☐ Thumb ☐ CMC ☐ MP ☐ IP
☐ Wrist
☐ Forearm
☐ Elbow

Orthotic Use:
☐ PRN
☐ Continuous
☐ Protective
☐ Nighttime

☐ Prefabricated Orthotic/Supplies
☐ Joint Jack Orthosis
☐ LMB/Capner Dynamic Finger Extension Orthotic
☐ Edema Control Device
☐ Scar Pads
☐ Putty
☐ Other ________________________________

☐ Evaluate & Treat
☐ Custom Orthotic
☐ Therapeutic Exercise
☐ Prefabricated Orthotic/Supplies

Requested Location _________________________________ Requested Therapist _________________________________

Next physician appointment ______________________________________________________________________________________________

Signature _________________________________ Physician Print Name _________________________________ NPI / MSID # _________________________________ Date __________ Time __________ Phone/Pager ID __________