movement for life
physical therapy

hand therapy treatment referral

PATIENT'S NAME: ..... PATIENT'S PHONE: .....

DIAGNOSIS: ..... DOB: .....

PRECAUTIONS: .....

rehabilitation

- ☐ **Evaluate & Treat**
- ☐ Therapeutic Exercise (Active, Passive, A/AROM)
- ☐ Thermal Modalities (Paraffin, heat, ice, Fluido)
- ☐ Order adaptive equipment, home units, TENS, etc.
- ☐ Myofascial Release
- ☐ Home Program
- ☐ Scar Mobilization/Desensitization

# of Strands per Repair: .....

Preferred Protocols:

- ☐ Therapist Discretion/Other: .....

splinting

Custom Splinting: (circle as desired)

- ☐ Static / Dynamic / Static-Progressive
- ☐ Digit / Hand / Wrist / Forearm based
- ☐ **Therapist Discretion**

Position: (in degrees)

MCPs ..... Wrist .....

PIPs ..... Elbow .....

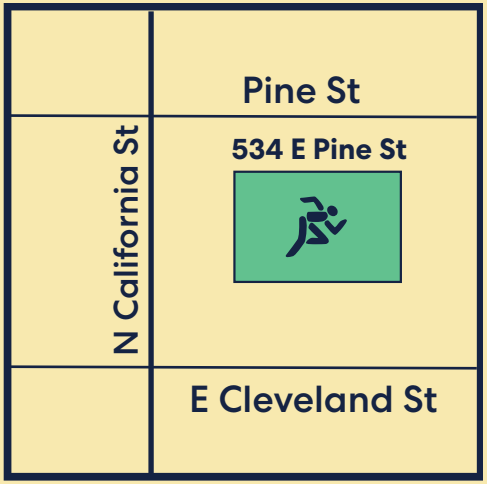
DIPs .....

Comments / Parameters: .....

.....

Frequency: ..... times per week for ..... weeks. Signature: ..... Date: .....

the experts
in movement



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