

Doctor's Referral / Prescription Form

Hand Therapy / Occupational Therapy Referral

| | |
|---------------------------------------|-------------------------|
| Referring Physician / Practice: _____ | Phone: _____ Fax: _____ |
| Address: _____ | Date: _____ NPI: _____ |

Patient Information

| | | |
|-----------------------|-----------------------------------|---|
| Patient Name _____ | DOB _____ | Phone _____ |
| Diagnosis _____ | Date of Injury / Surgery _____ | Affected Side Right / Left / Bilateral |

Prescription / Treatment Order

Diagnosis / ICD-10: _____

Treatment Diagnosis / Clinical Notes: _____

Precautions / Contraindications: _____

Post-op Protocol / Restrictions: _____

Requested Treatment

- Evaluate and treat
- Custom splint/orthosis fabrication
- Range of motion/strengthening
- Edema management
- Scar management/desensitization
- Modalities as indicated
- Home exercise program
- Other: _____

| | | |
|------------------------------------|-----------------------------|--------------------------------|
| Frequency _____ visits per week | Duration _____ weeks | Total Visits _____ visits |
| Start Date _____ | Follow-up MD Visit _____ | Activity As tolerated _____ |

Physician Authorization

| | |
|------------------------------|---------------|
| Physician Signature _____ | Date _____ |
|------------------------------|---------------|

