Certified Hand Therapist (CHT) & Occupational Therapist
162 Los Gatos-Saratoga Road, Los Gatos, CA 95030
Phone: 408-691-1825 | Fax: 1-341-225-4352
www.thrivehandtherapy.com

HAND & UPPER EXTREMITY THERAPY PRESCRIPTION

Patient Name: _____ **DOB:** _____

Phone: _____ **Date of Rx:** _____

Diagnosis: _____

Surgical Procedure: _____

Referring Physician: _____

ORDERS / INTERVENTIONS

[ ] Evaluate and Treat

[ ] ROM: [ ] AROM [ ] PROM

[ ] Wound / Pin Care

[ ] Strengthening

[ ] Ergonomic Education

[ ] Custom Orthotic / Splint: _____

[ ] Scar / Edema Management

[ ] Modalities (Heat/Ice/Ultrasound)

[ ] Education / Home Exercise Program

[ ] Desensitization / Sensory Retraining

Precautions / Restrictions: _____

Frequency: _____ times / week **Duration:** _____ weeks

_____
MD / DO / PA / NP Signature & Date

Please fax completed prescription to Thrive Hand Therapy • Fax: 1-341-225-4352