SUMMIT REHABILITATION L.L.C.

Hand Therapy Prescription

LAKE STEVENS • MARYSVILLE • MILL CREEK
SNOHOMISH • SULTAN

Patient:_____ Date: _____

Diagnosis:_____

Date of Injury:_____ Date of Surgery:_____

Procedure:_____

Precautions/Remarks:_____

_____

X-ray / Test Results:_____

Instructions: ❑ **Evaluate and Treat**
❑ **Discuss with MD Prior to Treatment**

Evaluation Only:
❑ Initial
❑ **Splint**

Dressing Change:
❑ Frequency:_____
❑ Type:_____

ORTHOSIS: ❑ Right ❑ Left

❑ **Finger**
❑ Static
❑ Dynamic:_____
_____
❑ Hand-based

❑ **Thumb Spica**
❑ Hand-based
❑ Forearm-based

❑ **Wrist Cock-up**
❑ Custom
❑ w/Finger gutter support
❑ Resting hand (all fingers)

❑ **Elbow**
❑ Sugar tong
❑ Hinge
❑ Flexion blocking
❑ Other:_____

Treatment

❑ Pain control
❑ Edema Management
❑ Range of Motion
❑ Joint protection
❑ Strengthening
❑ Passive ROM
❑ Scar management
❑ Soft Tissue Mobilization
❑ Active ROM

Specifics (Isolated/composite, when to begin, which joints):_____
_____

Treatment Plan: ❑ **Therapist Discretion**

Frequency/Duration: 1 2 3 4 5 times per week for_____ weeks

Additional Comments:_____
_____
_____
_____

Physician Re-Check Date: ____/____/____

Physician's Signature: _____

Thank you for this referral.

01/13