

Occupational Therapy Referral

prescription

Patient Name _____ Date of Birth _____ Phone Number _____

Insurance Provider _____ Insurance ID _____

Diagnosis _____ ICD10 CODE _____

Date of Injury _____ Date of Surgery _____

- Therapist evaluate and determine use of procedures, modalities, and / or frequency of treatment
- Precautions _____

OCCUPATIONAL THERAPY

- Evaluate & Treat
- Wound Care
(suture removal, bandage changes)
- ROM/Strength/Function
- Modalities (please specify)

RETURN TO WORK

- Work Conditioning
- Ergonomic Assessment
- FCE

CUSTOM SPLINT/ORTHOSIS

- Thumb/finger based (mallet, gutter, Stax)
- Hand based static
(metacarpal fracture, CMC OA)
- Hand based dynamic
- Forearm based dynamic
(post flexor/extensor tendon repair)
- Forearm based static
(wrist cockup, CTS, deQuervain's)
- Resting hand/wrist
- Elbow (cubital tunnel syndrome)
- Activity Related - Work/Sports

Treatment Frequency _____ x-per week or _____ weeks, or _____ PRN

Physician Signature _____ Date _____

Physician Name _____ Physician Phone _____