CASCADE
REHABILITATION ASSOCIATES

Hand Therapy Prescription

Patient:_____ Date: _____

Diagnosis:_____

Date of Injury:_____ Date of Surgery:_____

Procedure:_____

Precautions/Remarks:_____

_____

X-ray / Test Results:_____

Instructions: ❑ **Evaluate and Treat** **Report by:** ❑ Phone ❑ Letter

❑ **Discuss with MD Prior to Treatment** ❑ **Pediatric Hand Therapy**

Evaluation Only:
❑ Initial
❑ Sensorimotor

Dressing Change:
❑ Frequency:_____
❑ Type:_____

ORTHOSIS: ❑ Right ❑ Left

❑ **Finger**	❑ **Thumb Spica**	❑ **Wrist Cock-up**	❑ **Elbow**
❑ Static	❑ Hand-based	❑ Pre-fabricated	❑ Sugar tong
❑ Dynamic:_____	❑ Forearm-based	❑ Custom	❑ Hinge
_____	❑ Rigid	❑ w/Finger gutter support	❑ Flexion blocking
❑ Hand-based	❑ Neoprene	❑ Resting hand (all fingers)	❑ Other:_____

Range of Motion	**Treatment**	**Modalities**
❑ **Passive** ❑ **Active**	❑ Joint protection	❑ Therapist Discretion
❑ Flexion/extension	❑ Strengthening	❑ _____
❑ Flexion only	❑ Pain control	**Other:**_____
❑ Extension only	❑ Edema management	_____
❑ Pronation/supination	❑ Scar management	
	❑ Soft Tissue Mobilization	

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

_____

Treatment Plan: ❑ **Therapist Discretion**

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

Additional Comments:_____

_____

Physician Re-Check Date: ____/____/____

Physician's Signature: _____

Thank you for this referral.

02/09