PHYSICAL THERAPY/ HAND THERAPY PRESCRIPTION

PATIENT INFORMATION

Name:______________________________ Date of Birth:______________________________

Phone:______________________________ Date of Onset/Surgery:______________________________

Diagnosis:____

Precautions/Contraindications/Comments:____

INSURANCE INFORMATION

Insurance:____________________________________ Insurance ID Number: ____________________

Insurance Phone Number:____

EVALUATE AND TREAT

□ Physical Therapy □ Hand Therapy

PROCEDURES

- □Mobilization and Manual Therapy Technique
- □Traction (Cervical/Pelvic)
  - ○Provide Home Traction Unit
- □Gait/Transfer Training/Crutch Training
  - ○NWB ○TDWB ○PWB ○WBAT
- □Postural Training/ Body Mech/Pt Education
- □Therapeutic Exercise
  - ○ROM ○Strength ○Proprioception
- □Modalities Prn
  - ○Specific Request (please list): ________________

GOALS

- □Increase Strength and ROM
- □Decrease Pain
- □Improve Body Mech and Posture
- □Decrease Swelling
- □Independent Home Ex Program
- □Improve Function/ADL
- □Other:____________________________________

____

____

SPECIALTY PROGRAMS

□Motion Lab □Dance Medicine □Jump Training □Throwing Program □Running Program □Pilates
□Custom Orthotic: Fit and Fabrication

HAND THERAPY

- □Custom Splinting
- □Static Splinting ________________
- □Dynamic Splinting______________
- □Lateral/Medial Epicondylitis Eccentric Program
- □Hand OA Education Program
- □Other____

TREATMENT PLAN

Frequency:___________________ Duration:____________________

Please Schedule With:________________________________Within: □72 hrs □1 wk □1-2wks □Other:_______________

Physician Signature____ Date:_________________________________

Rebound Physical Therapy and Hand Therapy Call Center (360) 449-8700
Fax this form and records to: (360) 449-8776
Office Hours: 7:00 a.m. to 5:00 p.m.

We will contact the patient directly to schedule an appointment after receiving your fax.