

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Surgery: \_\_\_\_\_

Surgery Date: \_\_\_\_\_ Date Injured: \_\_\_\_\_

Next Dr. Appointment: \_\_\_\_\_

Precautions: \_\_\_\_\_

Treatment Frequency/Week: \_\_\_\_\_ # Weeks: \_\_\_\_\_

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### HAND / OCCUPATIONAL / PHYSICAL THERAPY

- |   |   |                                       |  |  |
|---|---|---------------------------------------|--|--|
| <input type="checkbox"/> Evaluate & Treat               | <input type="checkbox"/> Whirlpool                                |                                       |  |  |
| <input type="checkbox"/> Functional Capacity Evaluation | <input type="checkbox"/> Fluidotherapy                            |                                       |  |  |
| <input type="checkbox"/> Sensory Evaluation             | <input type="checkbox"/> Paraffin                                 |                                       |  |  |
| <input type="checkbox"/> Edema Control                  | <input type="checkbox"/> Ultrasound/ Phonophoresis                |                                       |  |  |
| <input type="checkbox"/> Scar Management                | <input type="checkbox"/> Iontophoresis                            |                                       |  |  |
| <input type="checkbox"/> Joint/ Tissue Mobilization     | <input type="checkbox"/> TENS                                     |                                       |  |  |
| <input type="checkbox"/> Desensitization                | <input type="checkbox"/> Neuromuscular Electrical Stimulation     |                                       |  |  |
| <input type="checkbox"/> Gait/ Balance Training         | <input type="checkbox"/> Traction                                 |                                       |  |  |
| <input type="checkbox"/> Self Care/ ADL's               | <input type="checkbox"/> Cervical <input type="checkbox"/> Pelvic |                                       |  |  |
| <input type="checkbox"/> Exercises: _____               |   |                                       |  |  |
| <input type="checkbox"/> AROM                           | <input type="checkbox"/> AAROM                                    | <input type="checkbox"/> PROM         | <input type="checkbox"/> Strengthening | <input type="checkbox"/> Stabilization |
| <input type="checkbox"/> BTE                            | <input type="checkbox"/> McKenzie                                 | <input type="checkbox"/> Home Program | <input type="checkbox"/> Stretch       |  |
| <input type="checkbox"/> Work Conditioning              |   |                                       |  |  |
| <input type="checkbox"/> Other _____                    |   |                                       |  |  |

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### PROGRAMS POST-OP / NON-SURGICAL

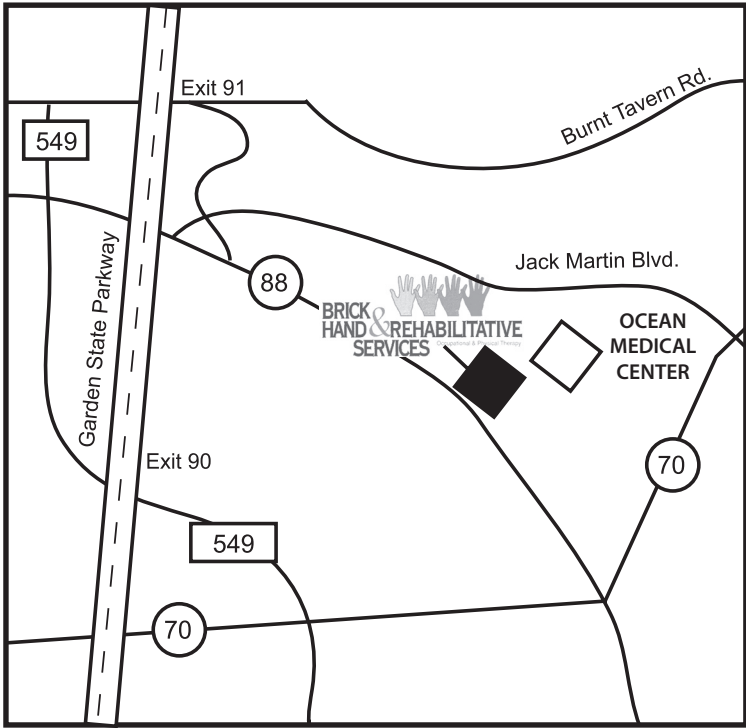
- |  |  |
|--|--|
| <input type="checkbox"/> Dupuytren's Contracture | <input type="checkbox"/> Jobst Garment                   |
| <input type="checkbox"/> Carpal Tunnel Syndrome  | <input type="checkbox"/> Custom Fracture Brace/ UE       |
| <input type="checkbox"/> Wrist Fracture          | <input type="checkbox"/> Scar Gel/ Elastomer Mold        |
| <input type="checkbox"/> Return to Work          | <input type="checkbox"/> Wound/Burn Care                 |
| <input type="checkbox"/> Cancer Reconditioning   | <input type="checkbox"/> Pain Management                 |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Sports Cast Protection Foam Pad |
| <input type="checkbox"/> Splinting _____         |  |

*I certify that this treatment and equipment is medically necessary as indicated over the next 30 days or other specified period.*

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

**DO NOT EMAIL PRESCRIPTION** The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.



**BRICK  
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