CAPE COD
HAND & UPPER EXTREMITY
THERAPY

Hand/ Upper Extremity Referral

Patient Name: _____ **Date:** _____

Date of Birth: _____

Patient Phone: (C) _____ **(W)** _____

Referring Provider: _____

Diagnosis / ICD- 10: _____

Precautions: _____

Eval & TX ☐ **Orthosis Only** ☐ **Orthosis and HEP** ☐

Orthotic Fabrication:

☐ **Thumb CMC**	☐ **Ulnar Gutter**	☐ **PIP Extension**
☐ **Wrist**	☐ **Radial Gutter**	☐ **Static Progressive**
☐ **Dorsal Wrist/ Hand**	☐ **Resting Hand/ Wrist**	☐ **Other:** _____
☐ **Trigger Finger**	☐ **Thumb Spica**	

Comments : _____

Referring Provider 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 hard copy that may be faxed, mailed or hand delivered to the clinic.

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