Cape Cod
HAND & UPPER EXTREMITY THERAPY

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Hand/Upper Extremity Therapy Referral

Patient's Name: _____ Date: _____

Patient's Phone: (h) _____ (c)_____

Referring MD: _____

Diagnosis: _____

Precautions: _____

Frequency/Duration: _____

Modalities

- ☐ Paraffin
- ☐ Contrast Bath
- ☐ Ultrasound
- ☐ Phonophoresis
- ☐ Iontophoresis
- ☐ Suture Removal
- ☐ Electrical Stimulation
- ☐ TENS
- ☐ Massage
- ☐ Would Care
- ☐ Cold Laser
- ☐ Game Ready Pneumatic Device

Theraputic Activities/Exercises

- ☐ PROM
- ☐ Joint Mobilization
- ☐ A/AROM
- ☐ Strengthening
- ☐ BTE
- ☐ Myofascial Release
- ☐ Theraband
- ☐ PRE's

Functional Restoration

- ☐ Joint Sparing
- ☐ ADL
- ☐ Desensitization
- ☐ Instruction in Home Prorgam
- ☐ Fine Motor Coord.
- ☐ Kinesiotaping

Orthotic Fabrication

- ☐ Thumb CMC
- ☐ Wrist
- ☐ Dorsal Wrist/Hand
- ☐ Trigger Finger
- ☐ Ulnar Gutter
- ☐ Thumb Spica
- ☐ Resting Wrist Hand
- ☐ PIP Extension
- ☐ Thumb Web Stretcher
- ☐ Dynamic MP Ext.
- ☐ Static Progressive

Orthotic Prescription: ☐

Post Op Tendon Program: ☐ Kleinert ☐ Duran

Arthroplasty Program: ☐

Rotator Cuff Program: ☐

Shoulder Arthroplasty Program: ☐

I hereby certify the above services to be medically necessary.

Physician's 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.