

THERAPY PRESCRIPTION

Patient Name: _____ Date: _____

Diagnosis: _____

Insurance Carrier: _____ Surgery Date: _____

Frequency: 1 2 3 4 5 x per week Duration: 1 2 3 4 5 6 weeks

PRIMARY EMPHASIS OF TREATMENT:

Evaluate and treat	Desensitization
Evaluation only	Strengthening
sensory	Pain Control
manual muscle test	Edema Control
Remobilization	Other _____
Wound Care	

SPECIFIC MODALITIES:

Heat/Ice	Whirlpool
TENS	Paraffin
Iontophoresis	Other _____
Ultrasound/phonophoresis	

SPECIFIC PROCEDURES:

Active ROM	Active Use
Active Assisted ROM	Dystrophile Program
Passive ROM	Other _____
Resistive ROM	

CUSTOM/PRE-FAB SPLINTS:

<u>Elbow</u>	<u>Wrist</u>	<u>Hand</u>	
Hinged Elbow	Gauntlet	Duran/Kleinert	Hand Based Fx
Long Arm	Neutral/Cock-up	Finger Tip	Joint Jack
Muenster	Thumb Spica	Short Opponents	Finger Ext.
Sugar Tong	Dynamic F/E	Figure 8	Dynamic F/E
Biceps	Dynamic Forearm	Forearm Based Fx	

Specify other: _____

 Physician's Signature

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