Patient Name

DOB, MR# or apply ID label above

EVALUATE AND TREAT:
Specific Orders:

☐ Edema Control

☐ Therapeutic Exercise
  ☐ AROM
  ☐ AAROM
  ☐ PROM
  ☐ Tendon glide  ☐ Nerve glide

☐ Strengthening
  ☐ Isometric
  ☐ Isotonic

☐ Modalities
  ☐ Iontophoresis with dexamethasone
  ☐ Ultrasound
  ☐ Other

☐ Other

☐ Splinting
  ☐ Static  ☐ Static Progressive  ☐ Dynamic
  ☐ Right  ☐ Left  ☐ Both

  (List specific position of joints to be included)

☐ Finger Based

☐ Hand Based

☐ Forearm Based

☐ Long Arm Based

☐ Other

☐ Wearing Schedule
  ☐ Protection  ☐ Remove for shower
  ☐ Night Time  ☐ Remove for light activity/exercise
  ☐ PRN  ☐ Do Not Remove

Significant History/Precautions:

Visits  or Frequency: ☐ PRN  1x  2x  3x / wk  Other

Return to MD by:  Duration: ☐ PRN  1  2  3  4  5  6 wk  Other

MD Signature  Date  Time  Received by:  Date  Time

HAND THERAPY ORDER