



# Hand Therapy Order Form

Referral Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Alt. Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Please complete insurance information below or submit a copy of the front and back of the insurance card with referral form.**

Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Next MD follow up visit at your facility: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

ICD-9 code: \_\_\_\_\_

Frequency: \_\_\_\_\_ times per week Duration: \_\_\_\_\_ weeks Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Evaluate and Treat**

Orthotic       Static       Dynamic      L code for orthotic: \_\_\_\_\_

Strengthen (97110)

ROM (97110)

Modalities:

E-Stim (97032)       Manual Therapy (97140)

Hot Pack (97010)       Neuromuscular Re-education (97112)

Cold Pack (97010)       Desensitization

Paraffin (97018)       Tendon Rehab Protocol

Ultrasound (97035)

Iontophoresis (97033)

Fluidotherapy (97022)

Home Program Instruction

Wound Care

Casting check one     long arm     short arm     cast to finger

I certify that therapy as outlined is medically necessary for the patient's progress toward anticipated goals. Ultimate frequency and duration is dependent on patient's progress.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_

Comments / Precautions: