4015 Lake Otis Parkway, Suite 200
Anchorage, AK 99507

www.akhandrehab.com

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Referral To:

PATIENT NAME:______________________________________________________________

DIAGNOSIS:_______________________________________________ICD-9:___________________

**FREQUENCY/DURATION: Please circle: 1 2 3 5 x/wk for _____weeks**

TREATMENT ORDERED:

_____**Evaluation and Treatment**

_____Evaluations
- _____Upper Quarter Screening
- _____Distal Nerve Latencies
- _____BTE Work Simulator
- _____Physical Capacities
- _____Impairment Ratings
- _____Validity Profile
- _____Worksite Assessment & Recommendations

_____Exercise
- _____Active / Active-Assistive / Passive
- _____Strengthening
- _____Work Hardening
- _____CPM: shoulder / elbow / wrist / fingers / thumb

_____Modalities
- _____**As indicated**
- _____Ultrasound/Phonophoresis (with Dexamethasone)
- _____Iontophoresis (E. Stim.with Dexamethasone)
- _____Functional Electrical Stim.
- _____Galvanic Electrical Stim.
- _____Tens/Pain Management
- _____Heat/Cold
- _____Paraffin
- _____Whirlpool

_____Soft Tissue Approaches
- _____Splints: Static / Dynamic
- _____Wound Care
- _____Edema Management
- _____Scar Management
- _____Pain Management
- _____Desensitization
- _____Sensory Re-education
- _____Myofascial Techniques

_____ Education
- _____Ergonomics
- _____Energy Conservation
- _____Body Mechanics
- _____Joint Protection
- _____Adaptive Aids

_____**Home Program**

_____**Supplies as needed**:_________________
________________________________________
________________________________________
________________________________________

INSTRUCTIONS/PRECAUTIONS:___________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

PHYSICIAN'S SIGNATURE:________________________________________DATE:_____________

**(907) 563-8318**
Fax (907) 563-3472

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