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REFERRAL

PATIENT NAME: _____ DOB: _____
DIAGNOSES: _____ ICD-9: _____
_____ ICD-9: _____
_____ 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
 - _____ 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 Lidex)
 - _____ Iontophoresis (E. Stimulation with Dexamethasone)
 - _____ Functional Electrical Stimulation
 - _____ Galvanic Electrical Stimulation
 - _____ 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: _____

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PHYSICIAN'S SIGNATURE: _____ DATE: _____