ALASKA HAND REHABILITATION

THERAPY FOR THE SHOULDER, ARM & HAND

4015 Lake Otis Parkway Suite 200
Anchorage, AK 99508
www.akhandrehab.com
P: 907.563.8318
F: 907.563.3472

PATIENT NAME: _____ **DOB:** _____

PATIENT PHONE NUMBER: _____

DIAGNOSIS/ICD-10: _____

FREQUENCY AND DURATION: _____ times per week for _____ week(s) beginning on _____

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/Finger(s)/Thumb

☐ **MODALITIES**
- ☐ **As indicated**
- ☐ Ultrasound/Phonophoresis (w/Lidex)
- ☐ Iontophoresis (E. Stim w/Dexamethasone)
- ☐ Functional Electrical Stimulation
- ☐ Galvanic Electrical Stimulation
- ☐ Tens/Pain Management Heat/Cold
- ☐ Paraffin
- ☐ Whirlpool

☐ **SOFT TISSUE APPROACHES**
- ☐ Splints: Static/Dynamic (Circle One)
- ☐ 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**

☐ **TELEREHAB**

☐ **SUPPLIES AS NEEDED:** _____

_____

INSTRUCTIONS/PRECAUTIONS: _____

_____

PROVIDER SIGNATURE: _____ **DATE:** _____

PROVIDER NAME (PRINTED): _____

FACILITY/OFFICE: _____

Our Team
Jean Keckhut, OTR/L, CHT
Libby Barnaby, OTR/L, CHT
Sheila King, OTR/L, CHT
Allison Horazdovsky, OTD, OTR/L
Liuslina Sooter, OTR/L, CHT, CLT
Tom Robinson, OTD, OTR/L
Daniel Jackson, OTD, OTR/L

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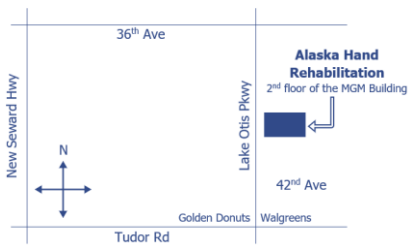

Please fax this referral to 907-563-3472 along with patient demographics and **medical records**.
Thank you for choosing Alaska Hand Rehabilitation.