OCCUPATIONAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ **MRN: _____**

DIAGNOSIS: HAND / WRIST _____
❒ Right ❒ Left ❒ Bilateral

Weightbearing status: ❒ NWB ❒ PWB ❒ WBAT

___ Anti-Inflammatory Modalities

___ Wrist Range of Motion ❒ Active ❒ Active-Assisted ❒ Passive

___ Digital range of motion

___ Desensitization therapy

___ Other: _____

Treatment: ❒ Eval and Treat or ❒ 1 ❒ 2 ❒ 3 times per week

Duration: ❒ 4 ❒ 6 weeks

❒ Home Program

**Please send progress notes.

Physician's Signature**: _____**

NPI #: 1164790507