OCCUPATIONAL THERAPY PRESCRIPTION

Jeffrey Wong, MD
SCOS Orthopedic Specialists
18785 Brookhurst Street, Ste 100
Fountain Valley, CA 92708
(714) 500-5056 Phone
(949) 900-2116 Fax

DATE: _____

PATIENT NAME: _____

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

DIAGNOSIS: DISTAL RADIUS FRACTURE
❒ 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