

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: _____

Right Left Bilateral

PROCEDURE: _____

DATE OF SURGERY: _____

Weightbearing status: NWB PWB WBAT

___ Anti-Inflammatory Modalities

___ Wrist Range of Motion Active Active-Assisted Passive

___ Digital range of motion

___ Desensitization therapy

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