

OCCUPATIONAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS: DISTAL RADIUS FRACTURE

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