Alaska Hand Rehabilitation
THERAPY FOR THE SHOULDER, ARM & HAND

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# REFERRAL

PATIENT NAME:_____DOB:_____
DIAGNOSES:_____ICD-9:_____
_____ ICD-9:_____
_____ICD-9: _____

**FREQUENCY/DURATION: Please circle: 1 2 3 5 x/wk for _____weeks**

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 / fingers / thumb

_____Modalities
- _____**As indicated**
- _____Ultrasound/Phonophoresis (with Lidex)
- _____Iontophoresis (E. Stimulation with Dexamethasone)
- _____Functional Electrical Stimulation
- _____Galvanic Electrical Stimulation
- _____Tens/Pain Management
- _____Heat/Cold
- _____Paraffin
- _____Whirlpool

_____Soft Tissue Approaches
- _____Splints: Static / Dynamic
- _____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**
_____**Supplies as needed**:_____
_____
_____
_____
INSTRUCTIONS/PRECAUTIONS:_____
_____
_____
_____
_____
_____
_____

**Phone: (907) 563-8318**
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PHYSICIAN'S SIGNATURE:_____DATE:_____