



HUDSON PRO ORTHOPAEDICS & SPORTS MEDICINE

New York: (646) 650-2229
New Jersey: (201) 308-6622
Fax: (201) 308-6623
info@hudsonproortho.com

OCCUPATIONAL/PHYSICAL THERAPY PRESCRIPTION

Today's Date: 10, 2, 23

Patient: Sumner, Toward

DOB: _____

Diagnosis: _____

back, neck

(L) shoulder, (R) elbow & (L) wrist

Frequency and Duration of Treatment: 2-3 X 6 wks

Precautions: _____

Continue Present Program: _____

MODALITIES:

- ☐ EVALUATE AND TREAT
- ☐ AS INDICATED
- ☐ HOT/COLD PACKS
- ☐ WHIRLPOOL
- ☐ ULTRASOUND
- ☐ PHONOPHORESIS
- ☐ IONTOPHORESIS
- ☐ E-STIM
- ☐ EDEMA CONTROL
- ☐ THERAPEUTIC MASSAGE

EXERCISES:

- ☒ STRENGTHENING EXERCISES
- ☒ STRETCHING EXERCISES
- ☐ ROM: AROM/AAROM/PROM
- ☐ ISOKINETIC EVAL/TRAINING
- ☐ GAIT TRAINING: FWB/PWB/NWB
- ☐ DESENSITIZATION
- ☐ ARTHRITIC JOINT PROTECTION PROGRAM
- ☐ ADL INSTRUCTION & ASSISTIVE DEVICES
- ☐ MCKENZIE PROGRAM
- ☐ JOINT MOBILIZATION

SPRINGS:

- ☐ STATIC
- ☐ DYNAMIC
- ☐ DIGITS
- ☐ THUMB ☐ INDEX ☐ LONG
- ☐ RING ☐ SMALL

OTHER:

- ☐ HOME PROGRAM
- ☐ WORK SIMULATION/BTE
- ☐ SEMMES-WEINSTEIN EVAL

- ☐ Imran Ashraf, MD ☒ Roman Isaac, MD ☐ Aleksey Lazarev, MD ☐ Thomas Azzolini, DPM ☐ Shital Sharma, DPM
- ☐ Edward H. Scheid, MD ☐ Robert Fraser, MD ☐ George Davydov, PA-C ☐ Peter Perou, RPA-C
- ☐ Irida Alvarez, PA-C ☐ Keyvan Jahanbakhsh, MD

_____, MD

Referring Physician Signature

This document should serve as a letter of medical necessity for therapy. The above has been prescribed by the treating physician and is medically necessary for the patient to reach maximum recovery. It is expected that PT/OT will be required for _____ months.

www.HudsonProOrtho.com

Please visit our website for more information on rehab protocols.

☐ Call STAT Report ☐ Phone Report

Please Provide Patient With: ☐ CD ☐ Film

Today's Date: 10/2/23

Patient: Simmons, Tounda

DOB: _____

Diagnosis ICD10 Code: _____

History: _____

Special Instructions: _____

① shoulder, ① wrist, ① elbow
MRE

GENERAL DIAGNOSTIC X-RAY

☐ Shoulder AP, Axillary, and Scapular Y
☐ Humerus AP and Lateral
☐ Elbow AP, Lateral, Internal & External Rotation
☐ Forearm AP and Lateral
☐ Wrist AP, Lateral and Oblique
☐ Hand AP, Lateral and Oblique

☐ L ☐ R
☐ L ☐ R
☐ L ☐ R
☐ L ☐ R
☐ L ☐ R
☐ L ☐ R

☐ Hips
☐ Femur
☐ Knee
☐ Tibia/Fibula
☐ Ankle
☐ Foot

Weight Bearing AP, Lateral and False Profile ☐ L ☐ R
AP and Lateral ☐ L ☐ R
Weight Bearing AP and Lateral, Sunrise ☐ L ☐ R
Tunnel View
AP and Lateral ☐ L ☐ R
AP, Lateral and Mortise ☐ L ☐ R
AP, Lateral and Oblique ☐ L ☐ R

Spine & Pelvis

☐ Cervical ☐ 5 views ☐ 2 views ☐ Scoliosis Study
☐ Sacrum & Coccyx ☐ Lumbar ☐ 4 views ☐ 2 views
☐ Thoracic/Dorsal ☐ 2 views ☐ Pelvis

Other: _____

☐ Extremity (specify): ☐ L ☐ R

CT SCAN

☐ Head
☐ Extremity (specify): _____
☐ Hip ☐ W/MAKOplasty
☐ Lumbosacral Spine
☐ Cervical Spine

☐ L ☐ R
☐ L ☐ R

☐ Thoracic Spine
☐ Knee ☐ W/MAKOplasty
☐ Foot
☐ Ankle
☐ Other (Specify) _____

☐ L ☐ R
☐ L ☐ R
☐ L ☐ R
☐ L ☐ R

☐ W/O Contrast ☐ W/ & W/O Contrast

CT ARTHROGRAM

☐ CT Arthrogram of: _____

☐ L ☐ R

MAGNETIC RESONANCE IMAGING (HIGHT FIELD OF VIEW)

☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine

☒ Shoulder ☒ R
☐ Knee ☐ L ☐ R
☐ Foot ☐ L ☐ R

☐ Hand
☐ Hip
☒ Elbow

☐ L ☐ R
☐ L ☐ R
☒ L ☐ R

☐ Ankle ☐ L ☐ R
☒ Wrist ☒ L ☐ R
☐ Other (Specify) _____

☐ W/O Contrast ☐ W/ & W/O Contrast

MR ARTHROGRAM

☐ MR Arthrogram of: _____

☐ L ☐ R

VASCULAR DOPPLER SOUND (VEGOTS)

☐ Venous Duplex ☐ Upper ☐ Lower ☐ Bilateral ☐ Unilateral ☐ Left ☐ Right

☐ Imran Ashraf, MD ☐ Roman Isaac, MD ☐ Aleksey Lazarev, MD ☐ Thomas Azzolini, DPM ☐ Shital Sharma, DPM
☐ Edward H. Scheid, MD ☐ Robert Fraser, MD ☐ Hebah El-Gendi, PA-C ☐ Peter Perou, RPA-C ☐ Iraida Alvarez, PA-C
☐ Prabhakar Reddy, MD ☐ Keyvan Jahannakhsh, MD

Referring Physician Signature _____

MD

APPOINTMENT CARD

atient Name: Simmons, Towanda

Appointment: Monday, October 16, 2023 at 10:00 AM

Provider: Roman Isaac, MD

Resource: Isaac, Roman

Facility: RI Newark office
235-239 MCWHORTER ST
NEWARK, NJ-07105-1032
Tel:201-308-6622 Fax:201-308-6623

Reason:



HUDSON PRO ORTHOPAEDICS & SPORTS MEDICINE

1320 Adams Street Suite D Hoboken, NJ 07030
Tel: (201)308-6622 Fax: (201)308-6623

Date: 10/02/2023

Towanda Simmons had an appointment in our office today.

Please allow the patient to return to: ☒ Full duty ☒ Light duty, if available
☒ Immediately or on date / /

☒ Left Extremity ☐ Right Extremity ☐ Both Extremities

Please allow the patient to return to light duty, if available with the following restrictions:

☐ No Use of the Hand/wrist /extremity

☐ No lifting, gripping, or carrying greater than pounds

Other restrictions: ☐ Do not get wet
☐ No driving
☐ No Typing
☐ No vibration tools
☐ Brace at all Times

☐ NO Restrictions

☒ NO overhead activity

Next appointment: 2 weeks. ☐ MMI

Comments:

Sincerely,

Roman Isaac M.D.