



**HUDSON PRO
ORTHOPAEDICS
& SPORTS MEDICINE**

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To: Dominique

Claim # PER039506

OCCUPATIONAL/PHYSICAL THERAPY PRESCRIPTION

Today's Date: 2/11/23

Patient: Garcia, Tracy DOB: _____

Diagnosis: _____

① wrist & hand

Frequency and Duration of Treatment: 2-3 x weekly

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

SPLINTS:

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

OTHER:

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

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Imran Ashraf, MD | <input checked="" type="checkbox"/> Roman Isaac, MD | <input type="checkbox"/> Aleksey Lazarev, MD | <input type="checkbox"/> Thomas Azzolini, DPM | <input type="checkbox"/> Shital Sharma, DPM |
| <input type="checkbox"/> Edward H. Scheid, MD | <input type="checkbox"/> Robert Fraser, MD | <input type="checkbox"/> Hebah El-Gendi, PA-C | <input type="checkbox"/> Peter Perou, RPA-C | |
| <input type="checkbox"/> Irida Alvarez, PA-C | <input type="checkbox"/> Prabhakar Reddy, MD | <input type="checkbox"/> Keyvan Jahannakhsh, MD | | |

Referring Physician Signature

MD

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.

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Please visit our website for more information on rehab protocols.