Hand Center of Oregon, Inc.

19365 SW 65th Ave., Suite 200
Tualatin, OR 97062

phone (503) 692-5210
fax (503) 692-8821

Date _____

Patient Name _____ Phone _____

Diagnosis _____ ICD-10 _____

Physician _____ Phone _____

Precautions _____

Treatment Goals & Objective _____

Frequency ☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X Duration _____ Weeks

Treatment

- ❑ Evaluate & Treat
- ❑ AROM
- ❑ PROM
- ❑ Strengthening Program
- ❑ Sensory Program
- ❑ Wound Care/Scar Remodeling
- ❑ Home Exercise Program
- ❑ Other _____

Splinting

- ❑ Static
  Type: _____
- ❑ Dynamic
  Type: _____
- ❑ Other _____

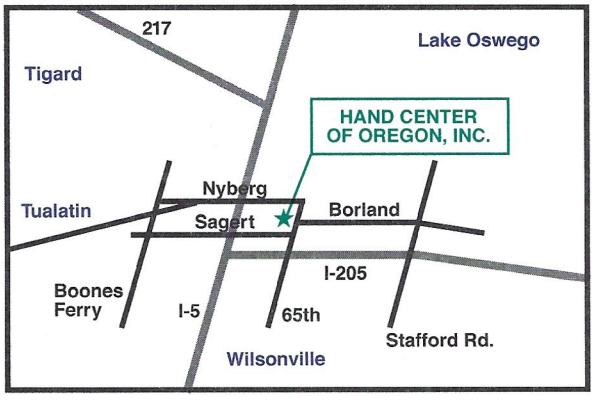
Modalities

- ❑ Hot Packs/Ice
- ❑ Fluidotherapy
- ❑ Ultrasound
- ❑ Iontophoresis
- ❑ TENS

I certify that the above treatment plan is medically necessary.

Physician Signature: _____

Date _____



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