

We know you have a choice in therapy providers, thank you for choosing Athletico.

OT/Hand Therapy Prescription

Patient Name: _____ DOI DOS: _____

Diagnosis: _____ Surgery Performed: _____

Frequency: 2x/Week 3x/Week 4x/Week 5x/Week Duration: 2 Weeks 4 Weeks 6 Weeks ____ Weeks

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Evaluate and Treat per Therapist Discretion <input type="checkbox"/> Edema Control <ul style="list-style-type: none"> <input type="checkbox"/> Coban <input type="checkbox"/> Isotoner <input type="checkbox"/> Ace Wrap <input type="checkbox"/> Digisleeve <input type="checkbox"/> Equipment/Supplies <ul style="list-style-type: none"> __Putty __Theraband __Aircast Armband __Hand Helper __Elbow Pad __Pulleys | <ul style="list-style-type: none"> <input type="checkbox"/> Modalities <ul style="list-style-type: none"> <input type="checkbox"/> Ultrasound <input type="checkbox"/> Electrical Stimulation <input type="checkbox"/> TENS <input type="checkbox"/> Paraffin <input type="checkbox"/> Iontophoresis/Direct Current with Dexamethasone <input type="checkbox"/> Phonophoresis <input type="checkbox"/> Hot/Cold Pack <input type="checkbox"/> Biofeedback <input type="checkbox"/> Whirlpool / Fluidotherapy <input type="checkbox"/> Scar Care/Management <ul style="list-style-type: none"> <input type="checkbox"/> Wound Care | <ul style="list-style-type: none"> <input type="checkbox"/> Industrial Rehabilitation Services <ul style="list-style-type: none"> <input type="checkbox"/> Functional Capacity Eval <input type="checkbox"/> Work Conditioning <input type="checkbox"/> Exercise <ul style="list-style-type: none"> <input type="checkbox"/> AROM <input type="checkbox"/> AAROM <input type="checkbox"/> PROM <input type="checkbox"/> Home Exercise Program <input type="checkbox"/> Evaluate and Treat per Therapist Discretion <input type="checkbox"/> Strengthening Program <ul style="list-style-type: none"> <input type="checkbox"/> Evaluate and Treat per Therapist Discretion <input type="checkbox"/> Splint: _____ <input type="checkbox"/> Protocol: _____ |
|--|---|---|

Date: _____ Signature: _____

IN MAKING THIS REFERRAL, THE PHYSICIAN/REFERRING PROVIDER CERTIFIES THAT PRESCRIBED REHABILITATION IS A MEDICAL NECESSITY.

ARLINGTON WEST
4407 Little Rd., Ste. 690, 76016
P: 682-282-4682 F: 682-219-0574
Clinician: Jasmine P., OTR/L, OTD

DALLAS RICHARDSON
7989 Belt Line Rd., Ste. 90, 75248
P: 972-942-2475 F: 972-645-0687
Clinician: Claire L., OTR/L, OTD

FRISCO PARKWOOD
3880 Parkwood Blvd., Ste. 501, 75034
P: 469-215-5870 F: 469-420-5792
Clinician: Abbey M., OTR/L, CHT

SOUTHLAKE
480 W. Southlake Blvd., Ste. 111
P: 817-778-9910 F: 817-203-0337
Clinicians: Ed R., OTR/L, CHT
Dardhielle J., OTR/L, CHT

DALLAS DOWNTOWN
1201 Elm St., Ste. 121, 75274
P: 469-620-5070 F: 469-983-1972

FORT WORTH KELLER
12345 Alta Vista Rd., Ste. 113, 76244
P: 682-593-2550 F: 682-582-8641
Clinician: Susan A., OTR/L

ROCKWALL NORTH
3005 N. Goliad St., 75087
P: 469-745-1935 F: 469-769-3002
Clinician: Luanne B., OT/L

THE COLONY
4770 State Highway 121, Ste. 130, 75056
P: 469-830-9030 F: 469-390-0010
Clinicians: Kristen G., OTR/L, CHT
Grace D., OTR/L, OTD
Kevin C., OTR/L, CHT

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To schedule Work Comp Patients or Services, including FCEs and Work Conditioning, Call **888-8-WORK4U** (888-896-7548) or Email **WORK4U@athletico.com**

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