

To schedule an appointment: 1719 8th Ave.  
 Fort Worth, Texas 76104  
 682-885-4063 phone  
 682-885-7590 fax

For this referral to be processed, all fields must be complete.

**Patient name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD-10 code(s):** \_\_\_\_\_

**Surgery date:** \_\_\_\_\_ **Follow-up with physician:** \_\_\_\_\_

- Surgery date:  Stat (24-48 hours)       High (<1 week)       Routine (2-3 weeks)  
 OT/PT evaluate and treat       Modalities as needed       Teach home program

**Specific modalities (as needed):** \_\_\_\_\_

**Restrictions/precautions/protocol:** \_\_\_\_\_

*The therapist will return the patient to community physical activities and/or sports when appropriate.*

- A/AA/PROM until week \_\_\_\_\_
- Soft tissue mobilization
- Edema control
- Sensory re-education/desensitization
- Scar management
- Pressure garment
- Strength training starting week \_\_\_\_\_

**Orthosis fabrication orders:**     Custom       Static       Dynamic

- Wrist cock-up       Thumb spica       Resting hand       Sugar tong
- Dorsal block       Ulnar gutter       Mallet       Elbow extension
- PIP extension       Elbow flexion       Post-op flexor tendon       Radial gutter

Other: \_\_\_\_\_

**Special instructions/comments:** \_\_\_\_\_  
 \_\_\_\_\_

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Physician signature \_\_\_\_\_ Date/time \_\_\_\_\_

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Physician name (printed) \_\_\_\_\_ Physician phone \_\_\_\_\_ Fax \_\_\_\_\_