RUSKINSTITUTE of Rehabilitation Medicine

REFERRAL FOR OUTPATIENT **HAND UNIT** (Please select OT or PT)

FAX to the RUSK BUSINESS OFFICE (212) 263-0113

Date: ___________

Patient Name: ____________________
Patient Date of Birth: ______________ Patient Social Security Number: _________
Patient Telephone Number: Contact 1: (_____)_____-_________
Contact 2: (_____)_____-_________
Patient Address: ____
____

Primary Insurance: __________ Policy Number: __________ Insured Name: _____________
Secondary Insurance: ________ Policy Number: __________ Insured Name: _____________

Medical Diagnosis: ____________________ ICD 9: _________________

_____ Wrist Fracture 715.13
_____ Lateral Epincondylitis 726.32
_____ Carpal Tunnel 354.0
_____ DeQuervain's 727.04
_____ Rheumatoid Arthritis 714.0
_____ Tendon Laceration 714.0

Onset Date: ______________________

Prescription for: (please select one)

______ Evaluation only
______ Evaluation and Treatment: _______ (times per week) ________ (number of weeks)

Treatment to Include: (please select)

_____ Splinting ________________
_____ AROM
_____ A/AROM
_____ PROM
_____ Strengthening
_____ Scar Management
_____ Desensitization Program
_____ Sensory Re-education
_____ Joint Protection
_____ Manual Therapy
_____ Self Care/ADL

Modalities to Include: (please select)

_____ Ultrasound _____________
_____ Electrical Stimulation
_____ Iontophoresis
_____ Fluidotherapy
_____ Paraffin
_____ Tens
_____ Moist Heat
_____ Ice Pack
_____ Contrast Baths
_____ Other ________________________

Physician's Name: ____
License Number: _________________ UPIN: _____________
Office Telephone: _________________ Office Fax: ______________
Physician's Signature: ____

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