

HAND THERAPY REFERRAL

Patient's Name: _____

Insurance Status: WC Private 3rd Party Vet Affairs

Phone No: Work _____ Home _____

Diagnosis: _____

Doctor's Order/Precautions/Contraindications: _____

Treatment Required (see below): Today 3-4 days no urgency

a) Treatment is requested for _____ wks at _____ times per week or as needed

b) Splint request only

EVALUATION

- UL Evaluation
- Independent Clinical Assessment
- UL Functional Capacity
- Job Analysis
- ADL Assessment

- Exercise Program
- Soft tissue/trigger point massage
- Scar/joint mobilisation
- Joint Protection
- Desensitisation/Sensory Re-Educ.
- CT Home Program
- TOS Home Program

EXERCISE

- Active ROM
- Passive ROM
- Active Assistive ROM
- Wrist/Hand CPM
- As per protocol
- Strengthening
- Neuromuscular Re-education

SPLINTAGE

- Protective thumb splint/hand bases
- Static finger protective/extension splint
- Static wrist resting splint
- Leather/neoprene thumb or wrist work splint
- Cubital tunnel resting splint
- Dynamic PIP extension/flexion splint finger/hand/forearm based
- Dynamic pronation/supination splint
- Dynamic flexor tendon splint
- Other _____

TREATMENT

- Modalities as needed
- Electrical Muscle Stimulation
- TENS
- Fluidotherapy

This referral was made by the following:

GP Specialist Therapist Claims Agent/Employer Rehabilitation Co-ordinator

Signature _____

Date _____



SA HAND THERAPY

Suzanne Caragianis & Associates



MAIN ROOMS

638 GOODWOOD RD
DAW PARK
PH: 8277 9667
FAX: 8277 0030
MON - FRI 8.30 - 5.15



NORTH ADELAIDE SPECIALIST CENTRE

53 GOVER STREET
NORTH ADELAIDE
PH: 8361 9888
FAX: 8361 7193
MON/WED/FRI 8.30 - 5.00



MAWSON LAKES SPECIALIST CENTRE

LEVEL 1, 1 MAIN STREET
MAWSON LAKES
PH: 8262 9999
FAX: 8359 7865
MON - THURS 8.30 - 5.00
FRI 8 - 12.30

ASSOCIATES:

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