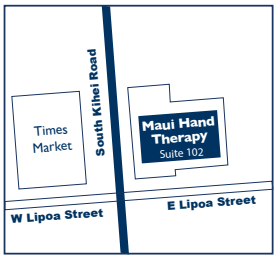
Health Quest Therapy, Inc.

formerly Maui Hand Therapy

Referral for Therapy Services



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www.HealthQuestTherapy.com

Patient Name: _____ Phone: _____

DOB: _____ DOI: _____ ICD - 10: _____

Diagnosis: _____

Procedure: _____

DOS: _____ Precautions: _____

Protocol: _____

Insurance Carrier: _____ ☐ Work Comp ☐ No Fault Claim # _____

Frequency / Duration (circle one) 1 2 3 4 5 x Week for _____ Weeks

Hand Therapy Treatment:

- ☐ Evaluation & Treatment
- ☐ Electrical Stimulation
- ☐ Cold Laser
- ☐ Ultrasound
- ☐ Manual Therapy
- ☐ Therapeutic Activities
- ☐ Heat/Cryotherapy
- ☐ ADL Re-training
- ☐ Therapeutic Exercise
- ☐ Iontophoresis
- ☐ Work Simulation
- ☐ Workstation Evaluation
- ☐ Orthotic Fabrication/Fitting/Education

Type of Splint: _____

Frequency and Duration of Splinting: _____

Other: _____

DOI (date of injury), DOS (date of surgery), and DOB (date of birth)

Physician's Name: _____ Signature: _____

Date: _____