Outpatient Occupational Therapy Hand Therapy Referral

1350 South Eliseo Drive, Suite 130 | Greenbrae, CA 94904
P: 415-945-7290 | F: 415-464-5462

☐ **Occupational/Hand Therapy**

Patient Name:______________________________ DOB: ____________

Diagnosis: ____

Date of Injury/Surgery: _____________________________________

Treatment

☐ Eval/Treatment: ____

☐ Splinting/Custom Orthosis (Specify Joint & Type):______________

☐ Protocol: ____

☐ Precautions/Additional Notes:______________________________

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____

Frequency/Duration: ________Times/Week **x** ________Weeks

This referral is for services that are medically necessary

Physician Name: ____

Physician Signature: _________________________Date:____________

*HMO, Medi-Cal, and Partnership coverage requires prior authorization for evaluation, treatment & custom orthosis/splint.