

**New York Hand Surgery  
New York Hand Surgery of Queens**

www.handsurgeon.com

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**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Therapy Prescription**  
**Occupational Therapy** \_\_\_\_ **Physical Therapy** \_\_\_\_

- |  |  |                             |
|--|--|-----------------------------|
| <input type="checkbox"/> Evaluate and Treat              | <input type="checkbox"/> Flexibility Training  | ___Desensitization protocol |
| <input type="checkbox"/> Rotator cuff program/therabands | <input type="checkbox"/> Balance Training      | ___Edema Protocol           |
| <input type="checkbox"/> AROM                            | <input type="checkbox"/> Gait Training         | ___Tendon Gliding           |
| <input type="checkbox"/> AAROM                           | <input type="checkbox"/> Quad STR Program      | ___Scar Management          |
| <input type="checkbox"/> PROM                            | <input type="checkbox"/> Low Back Program      |                             |
| <input type="checkbox"/> Strengthening                   | <input type="checkbox"/> Home Exercise Program |                             |

**Modalities:**

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Moist Therapy | <input type="checkbox"/> TENS        | <input type="checkbox"/> Iontophoresis |
| <input type="checkbox"/> Traction      | <input type="checkbox"/> Cryotherapy | <input type="checkbox"/> Ultrasound    |
| <input type="checkbox"/> Phonophoresis | <input type="checkbox"/> Parafin     | <input type="checkbox"/> As indicated  |

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

**Precautions:** \_\_\_\_\_

- Schedule per evaluation and need

**Physician Signature:** \_\_\_\_\_