OCCUPATIONAL THERAPY REFERRAL

Patients Name

Referring Healthcare Practitioner

Diagnosis

☐ CMC Osteoarthritis
☐ Carpal Tunnel Syndrome
☐ De Quervains Tenosynovitis
☐ Arthritis of Hand and/or Wrist
☐ Mallet Injury
☐ Boutinerre Deformity
☐ Finger Fracture
☐ Thumb Ulnar Collateral Ligament
☐ Other _____

Hand Involved: (please circle)
Right or Left or Both

Finger Involved: (please circle)
D1 (thumb) D2 (Index) D3 (middle) D4 (ring) D5 (little)

Treatment Required: (check all that apply)
☐ Custom Thermoplastic Splint(s) as appropriate
☐ Ax and treat as appropriate
☐ Physiotherapy treatment in conjunction with Splinting
☐ Other_____

Comments

Date

Signature

KW Custom Splinting

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