Health Sciences Centre
Winnipeg

OUTPATIENT HAND THERAPY REFERRAL

☐ **Occupational Therapy**
☐ **Physiotherapy**
☐ **Physiotherapy or Occupational Therapy as Needed**

DATE	HSC NO.
PATIENT	
DOB	
PROV HC#	
DOCTOR	
CLINIC/UNIT	LOC'N

Date of Injury: ____________________

Date of Surgery: ____________________

WCB/MPI#: ____________________ **Sex:** ______

Address: ____________________

Involved Extremity: ☐ Right ☐ Left

Phone: (H) __________ (W) __________ (C) __________

PRIORITY 1A

☐ Early Active Flexor Tendon Repair Tendons ______ Zone ______ Digits ______ Suture ______ Pulley repair ______	☐ Early Active Extensor Tendon Repair Tendons ______ Zone ______ Digits ______ Suture ______	☐ Flexor Tenolysis* ☐ Extensor Tenolysis* Tendon ______ Condition of Tendon ______ ______ Intraop. ROM ______	☐ Intra-articular # traction splint Digit/Phalanx ______

☐ Replant ____________________

Range of Motion parameters ____________________

PRIORITY 1B

☐ Flexor Tendon Repair/ Transfer Tendons ______ Zone ______ Digits ______ Suture ______ Pulley repair ______	☐ Extensor Tendon Repair Tendons ______ Zone ______ Digits ______ Suture ______	☐ Fracture, stable fixation for immediate active motion Fracture location/fixation ______ ______ ☐ Arthroplasty*Joint ______	☐ Dupuytren's Release* Digits ______ Graft ☐ YES ☐ NO ☐ Capsulotomies* ______ ______ Intraop. ROM ______

PRIORITY 2

☐ Dorsal dislocation, dorsal blocking splint at ______ degrees Digit/Jt. ______ Stable for ROM ☐ YES ☐ NO	☐ Volar dislocation Digit/Jt. ______	☐ CRPS ☐ Contractures < 3 months duration	☐ Carpal Tunnel Release* ☐ Nerve Decompression* ______ ☐ Nerve Transposition* ______
☐ Wrist # or Osteotomy Type/Location______ ______ Fixation ______ Start AROM Date: ______ Start PROM Date: ______	☐ Digit Fracture/Osteotomy Fracture location ______ ______ Fixation ______ Start AROM Date: ______ Start PROM Date: ______	☐ Skin Graft Stable for ROM ☐ YES ☐ NO ☐ Flap ______ Position for immobilization ______ ______ Start ROM Date: ______	☐ Nerve Repair Nerve ______ Location ______ Tension at ______ degrees

PRIORITY 3

☐ Nerve Compression Nerve ______ Level ______	☐ Contractures >3 months duration	☐ Tendonitis ______	☐ Other Condition (Specify) ______ ______

**Appointment should be arranged when surgery is booked*

Treatment Requested ____________________

Contraindications/Complications/Restrictions ____________________

Comments ____________________

Physician Signature ____________________ **Date** __________

FORM # NS00751 10/05 WHITE COPY - MEDICAL RECORD YELLOW COPY - APPROPRIATE DEPARTMENT

HSC is an operating division of the Winnipeg Regional Health Authority