

PHYSICAL THERAPY PRESCRIPTION

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PATIENT STICKER

Diagnosis: (LEFT / RIGHT) Distal Radius Fracture

DATE: _____

WRIST PHYSICAL THERAPY PRESCRIPTION

___ Elbow, Wrist and Hand Range of Motion Active / Active-Assisted / Passive

___ Emphasize Supination

___ Weightbearing as tolerated once healing visible on radiographs

___ Hand, wrist and forearm strengthening

___ Desensitization exercises and scar massage

___ Modalities PRN Ultrasound / Phonophoresis / E-stim / Moist Heat / Ice

Treatment: _____ times per week ___ Home Program

Duration: _____ weeks

Physician's Signature: _____

Joel Weber, MD, Orthopaedic Surgeon