Custom Hand Splinting & Therapy Services
Melissa Heidebrecht OT Reg. (Ont.)
durhamcustomsplinting.com
Contact: info@durhamcustomsplinting.com

	Name:	Phone Number:
Patient/client		
Referring Health Care Provider		

Diagnosis (if known) – Check any or all that apply:

☐ CMC osteoarthritis	☐ Boutinerre Deformity
☐ Carpal tunnel syndrome	☐ Finger/hand Fracture
☐ de Quervains Tenosynovitis	☐ Thumb Ulnar Collateral Ligament
☐ Arthritis of hand and/or wrist	☐ Mallet finger injury
☐ Dupuytren's contracture	Other: _____

Hand involved (circle)*:* Right or Left or Both

Finger(s) involved (circle): D1(Thumb) D2(Index) D3(Middle) D4(Ring) D5(Small)

Treatment Instructions (check any or all that apply):

- ☐ Assess and treat as appropriate.
- ☐ Custom Thermoplastic splint(s) as appropriate.
- ☐ Hand therapy services
- ☐ Other: _____

Comments:_____
_____
_____

Date: _____

Signature of referring health care practitioner: _____

(Please complete this form for the client and contact DCS at the email provided above to book an appointment)