PHYSICIAN ORDER AND PRESCRIPTION

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Social Security: _____

Insurance Co. _____ ID: _____ Date of Birth: _____ Male: ___ Female: ___

Waist Circumference (around belly button): _____ Shoe Size: _____ Knee Circumference: _____

WRIST/HAND:

- ☐ Carpel Tunnel Syndrome (354.0)
- ☐ Sprains & Strains of Wrist and Hand (842.00)
- ☐ Other: _____
- ☐ Other: _____

NECK/SPINE:

- ☐ Lumbosacral Radiculitis (724.4)
- ☐ Spinal Stenosis (724.02)
- ☐ Muscle Weakness (723.1)
- ☐ Cervicalgia (756.12)
- ☐ Lumbar Disc Displacement (722.10)
- ☐ Lumbar/Lumbosacral Disc Degeneration (722.52)
- ☐ Lumbosacral Plexus Lesion (353.0)
- ☐ Lumbar Strains/Sprain (847.2)
- ☐ Osteoporosis (733.0)
- ☐ Other: _____

KNEE/LEG:

- ☐ Rheumatoid Arthritis (714.0 – 714.4)
- ☐ Osteoarthritis (715.16) (715.26) (715.36) (715.96)
- ☐ Knee Instability (718.86)
- ☐ Other: _____
- ☐ Sprain of the Lateral Collateral Ligament (844.0)
- ☐ Sprain of the Medial Collateral Ligament (844.1)
- ☐ Sprain of the Cruciate Ligament of the Knee (844.2)
- ☐ Other: _____

For Spine bracing please check the applicable option(s):

- ☐ To facilitate healing following a surgical procedure on the spine or related soft tissue
- ☐ To facilitate healing following an injury to the spine or related soft tissue
- ☐ To reduce pain by restricting mobility of the trunk
- ☐ To otherwise support weak spinal muscles and/or a deformed spine

PLEASE DISPENSE THE FOLLOWING PRODUCT (S)

☐ **L0631 Prolign Pro® Lumbar Orthosis** – Sagittal control with Rigid Anterior Insert to provide support to the Intra-Abdominal and Viscera Region helping to unload the spine under gravitational load. Posterior plastic insert to Maintain neutral sagittal alignment. Extends from sacrococygeal junction to T9 vertebra.					
☐ **L2114 Cam Walker-** semi-rigid, prefabricated, includes fitting and adjustment	☐ **LT**	☐ **RT**	☐ **L1971 Ankle Foot Orthosis-** plastic or other material with ankle joint prefabricated w/ fittings	☐ **LT**	☐ **RT**
☐ **L3908 Univ. Wrist Splint-** rigid w/o joint(s)	☐ **LT**	☐ **RT**	☐ **L3807 Univ. Thumb Spica**- w/o joint(s)	☐ **LT**	☐ **RT**
☐ **L0174 Universal XTW Cervical Collar**- Cervical Collar, Semi-Rigid w/ Thermoplastic Foam. Two Pieces w/ Thoracic Ext.					
☐ **L1832 Warrior® Pro Knee Brace** - Knee Orthosis, Adjustable Knee Joints (Unicentric or Polycentric), Positional Orthosis, Rigid, Support, For Mild to Moderate ACL, PCL, MCL, LCL, or Combined Ligament instabilities.				☐ **LT**	☐ **RT**

☐ **TENS UNIT 3900**	☐ **NEBULIZER E0570**	☐ **ANKLE AIRCAST L4350**	☐ **CANE E0100**	☐ **QUAD-CANE E0105**

Rx: Estimated Length of Need (#of months) _____ 1-99 (99=Lifetime)

This patient is being treated under a comprehensive plan of care for orthopedic pain management. I the undersigned certify that the prescribed orthosis is medically necessary for the patient's overall treatment of:

Physician Signature: _____ Date: _____ NPI: _____

Print Physician Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____