STANDARD WRITTEN ORDER

REQUIRED - ORDER DATE: ______________

Patient Name:____ DOB: _______________

Patient Address: ____

Patient Phone # : ____

Date of Injury:________________ Date of Surgery: ______________

Diagnosis Equipment is Prescribed for: ICD10: ____

ICD10: (2ndary) ____

Prescribed Device: ☐ Shoulder ☐ Elbow ☐ Pro/Sup ☐ Wrist ☐ Finger ☐ Thumb ☐ MCP Joint ☐ Knee ☐ Ankle ☐ Toe

Affected Side: ☐ Left ☐ Right ☐ Bilateral

This Prescription is valid for 12 months unless otherwise notated below.

Length of Need: ☐ 1 Month ☐ 3 Months ☐ 6 Months ☐ 10 Months

Affected Motion:

☐ Extension ☐ Flexion ☐ Pronation ☐ Supination

☐ External Rotation ☐ Internal Rotation ☐ Dorsiflexion ☐ Plantar Flexion

I certify that the above prescribed equipment is medically indicated and in my opinion, is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition and is not prescribed as "convenience" equipment. I ask that there be no equipment substitutions for the devices prescribed.

Physicians Name (Please Print) ____

NPI: _______________________ Phone #: ____

Street Address: ______________________________ City: __________________ State: ________

Physicians Signature: ____ Date: ________________

Please Fax to: 217-347-3384

Rev 04/24