

SECTION 1 — PATIENT & INSURANCE INFORMATION REQUIRED

Patient Name _____ DOB (MM/DD/YY) ____________ Gender _____
 Address _____ City _____ State _____ ZIP _____
 Primary Phone _____ Secondary Phone _____ Email _____
 Primary Insurance _____ Member ID _____ Primary Language, if not English _____
 Secondary Insurance _____ Member ID _____ Is this a workplace injury? Yes No

If patient is not insured, write SELF PAY in this section

Please attach medical records and copies of the front and back of all insurance cards with each order.

SECTION 2 — PRESCRIBED THERAPY REQUIRED

OA Knee Brace

Left Right

Knee, OA - Left M17.12
 Knee, OA - Right M17.11
 Bilateral knee, OA M17.0
 Unspecified knee, OA M17.10
 Unspecified, OA M17.9
 Other Dx _____

Post-Op Knee Brace *Thigh Circumference: ____ (in)*

QTY1 QTY2

Knee, OA - Left M17.12
 Knee, OA - Right M17.11
 Knee Pain - Left M25.562
 Knee Pain - Right M25.561
 Other acute post-procedural pain G89.18
 Other Dx _____

Wrist Brace

Wrist Circumference: ____ (in)

QTY1 QTY2

Wrist, Left G56.02
 Wrist, Right G56.01
 Bilateral wrists G56.03
 Carpal tunnel syndrome, unspecified G56.00
 Other Dx _____

Hot/Cold/Compression Therapy

Length of Need: _____ (1-24 months)

Dx Codes (s): _____, _____, _____

CryoHeat* Hot Cold

*ships with universal blanket + 4 reusable ice cubes

DynaComp, *treatment area required*

Ankle Knee Hip Back Shoulder

LSO/Back Brace

Waist Circumference: ____ (in)

Hybrid Low-Profile Only
 Standard Thoracic LSO

Spondylolisthesis M43.16
 Thoracic back pain M54.6
 Lumbar spondylosis M47.816
 Dorsalgia, unspecified M54.9
 Lumbar spinal stenosis M48.061
 Lumbar radiculopathy M54.16
 Low back pain, unspecified M54.50
 Other Dx _____

InWave - Probe Required

Small (4" L x 0.75" D) Large (5.5" L x 1" D)
 Length of Need: _____ (1-24 months)
 Sessions per day: _____ Minutes per session: _____

Stress urinary incontinence N39.3
 Urge urinary incontinence N39.41
 Mixed urinary incontinence N39.46
 Muscle weakness M62.81
 Other specified disorders of muscle M62.89
 Overactive bladder N32.81
 Other Dx _____

Cervical Traction

Length of Need: _____ (1-24 months)

Cervical spondylosis M47.812
 Cervical spinal stenosis M48.02
 Cervical radiculopathy M54.12
 Radiculopathy, lumbar region M54.16
 Cervicalgia M54.2
 Other Dx _____

SECTION 3 — PRESCRIBER ATTESTATION REQUIRED

By signing below, I confirm that the patient is being treated by me. All the information contained on this form accurately reflects the patient's medical condition and the treatment regimen I have prescribed. The medical records for this patient substantiate the prescribed treatment frequency. The patient/caregiver is able to follow instructions for using an e-stim device and is able to use the ordered items. I certify my patient has no medical contraindications making this therapy inappropriate, e.g., pace-maker. For Medicare/Insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Name: _____ License: _____ NPI: _____

Clinic Name: _____ Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ ZIP: _____

Prescriber Signature: _____ Date: _____