Physicians Orthotic Brace Order Form

Patients Name ______________________________ **Start Date:** ______________

Address: ____________________ **City:** ______________ **State:** ______________ **Zip:** __________

HT: ______ **WT:** ______ **DOB** ______________

Insurance #1: ________________________ **Insurance #2:** ________________________

Knee Braces

❑ Tru-Pull Knee DJO (L1810) ❑ Hinged Knee Brace BH (L1810) ❑ Hinged Air DJO (L1833)

❑ Quicksilver Knee AMP (L1833) ❑ Playmaker II DJO (L1833) ❑ Range Of Motion Sleeve BH (L1833)

❑ OA Lite DJO (L1843) ❑OA Clima-Flex Flex DJO (L1851) ❑ OA Everyday Knee DJO (L1852)

❑ OA Adjuster 3 DJO (L1852) ❑ OA Nano DJO (L1852) ❑ Ortho-Armor Immobilizer BH (L1830)

❑ **Other:** ________________________

Diagnosis ❑ ________________ ❑ ________________ ❑ ________________

Back/Spine Braces

❑ Evergreen SI Aspen (L0621) ❑ Pro-Tec SI (L0621) ❑ Evergreen Lumbar Lite Aspen (L0641)

❑ Flex Power Plus BH (L0642) ❑ Horizon 627 Aspen (L0642) ❑ Evergreen Lumbar Aspen (L0642)

❑ Comfort LSO AMP (L0642) ❑ Summit 631 Aspen (L0648) ❑Freedom LSO AMP (L0648)

❑ Premium Plus DJO (L0648) ❑ Summit 637 Aspen (L0650) ❑ LPR 2000 AMP (L0650)

❑ **Other:** ________________________

Diagnosis: ❑ ________________ ❑ ________________ ❑ ________________

Hand/Ankle/Shoulder/Cervical

❑ Wrist Brace BH (L3908) ❑ Wrist & Forearm BH (L3908) ❑ Thumb Spica BH (L3923)

❑ Wrist & Thumb BH (L3908) ❑ Ankle Stabilizer BH (L1902) ❑ Ankle Stirrup BH (L4350)

❑ Boot Walker Low BH (L4386) ❑ Boot Walker Tall BH (L4387) ❑ Boot Walker Air Low BH (L4360)

❑ Boot Walker Air Tall BH (L4360) ❑ AFO-RT BH (L1930) ❑ AFO-LT BH (L1930) ❑ Clavicle Support BH (L3650)

❑ Plantar Fasciitis Support BH (L1902) ❑ Shoulder Immob BH (L3650) ❑ Should Ultra Sling DJO (L3960)

❑ **Other:** ________________________

Diagnosis: ❑ ________________ ❑ ________________ ❑ ________________

***Qualifications and required documentation to be noted in charts notes to from Physician** ________*

LON: ________________ Additional Comments: ____

____

Physician or FNP Name: ____

Address: _______________________ City: ________________, State: ___________ Zip: _________

Phone: __________________________ Fax: _______________________

NPI #: ____________________________

Physician or FNP Signature: _____________________________________Date: ________________