

# DETAILED WRITTEN ORDER

PATIENT INFORMATION	Start Date of Order (MM/DD/YY) _____		Date of Birth _____		
	First Name _____		Last Name _____		
DYNASPLINT® SYSTEM(S) PRESCRIBED	<input type="radio"/> Jaw	<input type="radio"/> Internal Rotation	<input type="radio"/> Elevation	<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Shoulder	<input type="radio"/> External Rotation	<input type="radio"/> Flexion	<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Elbow	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Forearm	<input type="radio"/> Supination	<input type="radio"/> Pronation	<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Wrist	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Carpal Tunnel			<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Hand (MCP)	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Finger	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Knee	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Ankle	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right	<input type="radio"/> Left
	<input type="radio"/> Toe	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right	<input type="radio"/> Left
		<input type="radio"/> Varus	<input type="radio"/> Valgus	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
	<input type="radio"/> Hammer Toe	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right	<input type="radio"/> Left
				<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
	<input type="radio"/> External Fixator			<input type="radio"/> Right	<input type="radio"/> Left
ATTACHMENTS OR ACCESSORY ITEM(S)	<b>ACCESSORY ITEMS</b>				
	<input type="radio"/> Resting Hand/Wrist Orthosis <input type="radio"/> BendEase Hand <input type="radio"/> RestAir™ Hip Orthosis <input type="radio"/> Kentucky Kollar <input type="radio"/> NeuroFlex™ Restorative™ Knee Orthosis <input type="radio"/> NeuroFlex™ Restorative™ Elbow Orthosis		<input type="radio"/> MPO 2000 Active® Ankle-Foot Orthosis <input type="radio"/> Safeboot <input type="radio"/> Soft Padded Shoe (for use with Toe Dynasplint® Systems) <input type="radio"/> DS1971 Inversion/Eversion Control System <input type="radio"/> Replacement Soft Interface Material		
	<b>WRIST DYNASPLINT® SYSTEMS HANDPIECE ATTACHMENTS (SELECT ONE)</b>				
FIT	<input type="radio"/> Hand Pan "C" Cup Attachment <input type="radio"/> Padded Palmar Hand Attachment <input type="radio"/> Universal Flat Piece Hand Attachment		<input type="radio"/> Mitt Splint Hand Attachment <input type="radio"/> Anti-Spasticity Ball Hand Attachment <input type="radio"/> Progressive Hand Attachment		
	<input type="radio"/> Personalized Fitting				
ROM	ROM: _____ Frequency of Use: _____ Time(s) Daily / _____ Hour(s) Per Day				
DIAGNOSIS	Primary Diagnosis Code (PLEASE PROVIDE PATIENT CHART NOTES RELATED TO THIS DIAGNOSIS.) _____			Date of Onset/Surgery/Injury _____	
	Secondary Diagnosis Code (PLEASE PROVIDE PATIENT CHART NOTES RELATED TO THIS DIAGNOSIS.) _____			Date of Onset/Surgery/Injury _____	
LENGTH OF NEED	<input type="radio"/> 1 Month <input type="radio"/> 3 Months <input type="radio"/> 6 Months <input type="radio"/> 12 Months <input type="radio"/> Lifetime <input type="radio"/> Other: _____				
PHYSICIAN INFORMATION AND SIGNATURE	Physician's Name (PLEASE PRINT) _____			Phone Number _____	
	NPI Number _____			Fax Number _____	
	Street Address _____		City _____	State _____	Zip Code _____
	I certify that I am the treating physician identified on this detailed written order. I have received this completed detailed written order and agree with prescribing the items listed. This detailed written order has been reviewed and signed by me and I certify that all information is true and accurate to the best of my knowledge.				
SIGN AND DATE	Physician's Signature _____			Date _____	
	NOTE: Signature and Date Stamps are Not Acceptable.				