DETAILED WRITTEN ORDER

PATIENT INFORMATION

Start Date of Order (MM/DD/YY) _____ / _____ / _____

Date of Birth _____

First Name _____

Last Name _____

DYNASPLINT® SYSTEM(S) PRESCRIBED

○ Jaw				
○ Shoulder	○ Internal Rotation ○ External Rotation	○ Elevation ○ Flexion	○ Right	○ Left
○ Elbow	○ Extension	○ Flexion	○ Right	○ Left
○ Forearm	○ Supination	○ Pronation	○ Right	○ Left
○ Wrist	○ Extension	○ Flexion	○ Right	○ Left
○ Carpal Tunnel			○ Right	○ Left
○ Hand (MCP)	○ Extension	○ Flexion	○ Right	○ Left
○ Finger	○ Extension	○ Flexion	○ Right ○1 ○2 ○3 ○4 ○5	○ Left ○1 ○2 ○3 ○4 ○5
○ Knee	○ Extension	○ Flexion	○ Right	○ Left
○ Ankle	○ Dorsiflexion	○ Plantar Flexion	○ Right	○ Left
○ Toe	○ Dorsiflexion ○ Varus	○ Plantar Flexion ○ Valgus	○ Right ○1 ○2 ○3 ○4 ○5	○ Left ○1 ○2 ○3 ○4 ○5
○ Hammer Toe	○ Dorsiflexion	○ Plantar Flexion	○ Right ○1 ○2 ○3 ○4 ○5	○ Left ○1 ○2 ○3 ○4 ○5
○ External Fixator			○ Right	○ Left

ATTACHMENTS OR ACCESSORY ITEM(S)

ACCESSORY ITEMS

- ○ Resting Hand/Wrist Orthosis
- ○ BendEase Hand
- ○ NeuroFlex™ Restorative™ FlexHand
- ○ NeuroFlex™ Restorative™ Elbow Orthosis
- ○ Kentucky Kollar
- ○ RestAir™ Hip Orthosis
- ○ NeuroFlex™ Restorative™ Knee Orthosis
- ○ MPO 2000 Active® Ankle-Foot Orthosis
- ○ Safeboot
- ○ Soft Padded Shoe (for use with Toe Dynasplint® Systems)
- ○ DS1971 Inversion/Eversion Control System
- ○ Replacement Soft Interface Material

WRIST DYNASPLINT® SYSTEMS HANDPIECE ATTACHMENTS (SELECT *ONE*)

- ○ Hand Pan "C" Cup Attachment
- ○ Padded Palmar Hand Attachment
- ○ Universal Flat Piece Hand Attachment
- ○ Mitt Splint Hand Attachment
- ○ Anti-Spasticity Ball Hand Attachment
- ○ Progressive Hand Attachment

FIT

○ 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

○ 1 Month ○ 3 Months ○ 6 Months ○ 12 Months ○ Lifetime ○ 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 _____

NOTE: *Signature and Date Stamps are Not Acceptable.*

Date _____ / _____ / _____