DETAILED WRITTEN ORDER - SNF

PATIENT INFORMATION

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

First Name _____ Last Name _____

STATIC ITEMS TO ACCOMPANY THE PRESCRIBED DYNASPLINT® SYSTEM

○ NeuroFlex™ Restorative™ Progressive DH Hand	○ Right	○ Left
○ NeuroFlex™ Restorative™ Flex Hand	○ Right	○ Left
○ NeuroFlex™ Restorative™ BendEase Hand	○ Right	○ Left
○ NeuroFlex™ Restorative™ Elbow Orthosis	○ Right	○ Left
○ NeuroFlex™ Restorative™ Knee Orthosis	○ Right	○ Left
○ RestAir Hip Orthosis		
○ NeuroFlex™ Restorative™ SafeBoot	○ Right	○ Left

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.)*

Secondary Diagnosis Code *(PLEASE PROVIDE PATIENT CHART NOTES RELATED TO THIS DIAGNOSIS.)*

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 **Date** ____/____/____

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