STANDARD 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 standard written order. I have received this completed standard written order and agree with prescribing the items listed. This standard 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.*