STANDARD WRITTEN ORDER

PATIENT INFO

First Name _____ Last Name _____ Date of Birth _____ Start Date of Order _____

DYNASPLINT® SYSTEM(S) PRESCRIBED

	All Others	Medicare		
○ Knee Extension	○ E1810	○ E1813	○ Right	○ Left
○ Knee Flexion	○ E1810	○ E1814	○ Right	○ Left
○ Elbow Extension	○ E1800	○ E1803	○ Right	○ Left
○ Elbow Flexion	○ E1800	○ E1804	○ Right	○ Left
○ Ankle Dorsiflexion	○ E1815	○ E1822	○ Right	○ Left
○ Ankle Plantar	○ E1815	○ E1823	○ Right	○ Left
○ Wrist Extension	○ E1805	○ E1807	○ Right	○ Left
○ Wrist Flexion	○ E1805	○ E1808	○ Right	○ Left
○ Finger Extension	○ E1825	○ E1826	○ Right 1○ 2○ 3○ 4○ 5○	○ Left 1○ 2○ 3○ 4○ 5○
○ Finger Flexion	○ E1825	○ E1827	○ Right 1○ 2○ 3○ 4○ 5○	○ Left 1○ 2○ 3○ 4○ 5○
○ MTP Ext./Dorsiflexion	○ E1830	○ E1828	○ Right 1○ 2○ 3○ 4○ 5○	○ Left 1○ 2○ 3○ 4○ 5○
○ MTP Flexion/Plantar	○ E1830	○ E1829	○ Right 1○ 2○ 3○ 4○ 5○	○ Left 1○ 2○ 3○ 4○ 5○
○ Hammer Toe	○ E1830	○ E1830	○ Right 1○ 2○ 3○ 4○ 5○	○ Left 1○ 2○ 3○ 4○ 5○
○ Hallux Varus/Valgus	○ E1830	○ E1830	○ Right	○ Left
○ Shoulder	○ E1840	○ E1840	○ Internal Rotation ○ External Rotation ○ Right	○ Elevation ○ Flexion ○ Left
○ Forearm - Sup/Pro	○ E1802	○ E1802	○ Supination ○ Pronation	○ Right ○ Left
○ Hand (MCP) Extension	○ E1805	○ E1807	○ Right	○ Left
○ Hand (MCP) Flexion	○ E1805	○ E1808	○ Right	○ Left
○ Jaw	○ E1700	○ E1700		
○ Carpal Tunnel	○ E1399	○ E1399	○ Right	○ Left

ACCESSORY ITEM(S) OR ATTACHMENTS

- ○ Resting Hand/Wrist Orthosis - L3809
- ○ BendEase Hand - L3809
- ○ NeuroFlex™ Restorative™ FlexHand - L3809
- ○ NeuroFlex™ Restorative™ Elbow Orthosis - L3761
- ○ Kentucky Kollar - L0113
- ○ Restorative™ VertebrEase TLSO - L0456
- ○ Restorative™ VertebrEase LSO - L0631
- ○ RestAir™ Hip Orthosis - L1652
- ○ NeuroFlex™ Restorative™ Knee Orthosis - L1831
- ○ MPO 2000 Active® Ankle-Foot Orthosis - L4397
- ○ Safeboot - L4397
- ○ Soft Padded Shoe (for use with Toe Dynasplint® Systems) - E1399
- ○ Dynamic Control Boot - L1971
- ○ Replacement Soft Interface Material - E1820

WRIST / HANDPIECE ATTACHMENTS (SELECT ONE) L3924

- ○ Hand Pan "C" Cup
- ○ Anti-Spasticity ball
- ○ Mitt
- ○ Universal Flat
- ○ Padded Palmar
- ○ Progressive Hand

ROM

Initial ROM _____ Frequency of Use: Time(s) Per Day _____ 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)* _____

FITTING

○ Personalized Fitting

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.

Physician's Signature _____ ***NOTE:*** *Signature and Date Stamps are Not Acceptable* **Date** _____