PRESCRIPTION FORM/LETTER OF MEDICAL NECESSITY

PATIENT INFO:

PATIENT NAME:	CHECK ONE: M◯ F◯
ADDRESS:	CITY, STATE, ZIP:
CONTACT NUMBER:	CHECK ONE: MAJOR MED◯ WORKERS COMP◯ NO FAULT◯
SOCIAL SECURITY:	DATE OF ACCIDENT/INJURY(if applicable):
INSURANCE PROVIDER:	INSURANCE ID NUMBER:

ITEM(S) PRESCRIBED:	RECOMMENDED USAGE:*	PERIOD OF MEDICAL NEC:*
☐ ___TENS UNIT	☐ DAILY ___X PER WEEK	☐ 6MO ☐ 9MO ☐ 12MO
☐ ___CERVICAL COLLAR		☐ 6MO ☐ 9MO ☐ 12MO
☐ ___LUMBAR TRACTION	☐ DAILY ___X PER WEEK	☐ 6MO ☐ 9MO ☐ 12MO
☐ ___CERVICAL TRACTION	☐ DAILY ___X PER WEEK	☐ 6MO ☐ 9MO ☐ 12MO
☐ ___TLSO BRACE		☐ 6MO ☐ 9MO ☐ 12MO
☐ LSO BRACE		☐ 6MO ☐ 9MO ☐ 12MO
☐ ☐ NECK___ BACK ☐ ☐ ___COLD THERAPY UNIT	☐ DAILY ___X PER WEEK	☐ 6MO ☐ 9MO ☐ 12MO

AREAS TO BE TREATED:		PAIN SEVERITY:			
☐ LUMBAR SPINE	☐ CHRONIC	☐ SEVERE	☐ INTRACTABLE	☐ MILD	☐ MODERATE
☐ THORACIC SPINE	☐ CHRONIC	☐ SEVERE	☐ INTRACTABLE	☐ MILD	☐ MODERATE
☐ CERVICAL	☐ CHRONIC	☐ SEVERE	☐ INTRACTABLE	☐ MILD	☐ MODERATE
_____ OTHER	☐ CHRONIC	☐ SEVERE	☐ INTRACTABLE	☐ MILD	☐ MODERATE

ICD-10 DIAGNOSIS CODES:

LUMBAR CODES: ☐ M54.6 ☐ M54.5 ☐ M99.03 ☐ M43.27 ☐ M51.36 OTHER:_____

CERVICAL CODES: ☐ M99.01 ☐ S23.3XXA ☐ M54.2 ☐ M50.30 ☐ M62.40 OTHER:_____

I PRESCRIBE THIS EQUIPMENT BECAUSE(SYMPTOMS/OBJECTIVE FINDINGS):

_____

_____

TREATMENT GOALS *(CHECK ALL THAT APPLY)*: ☐ Relieve Patient's Condition ☐ Increase Range of Motion ☐ Manage Chronic Pain ☐ Achieve Stabilization ☐ Reduce Muscle Spasm ☐ Reduce Reliance of Pain Meds

PREVIOUS TREATMENTS:_____

DATE OF INITIAL VISIT:_____ **DATE LAST SEEN:**_____

I CERTIFY THAT THE ABOVE PRESCRIBED EQUIPMENT, IS BOTH REASONABLE AND MEDICALLY NECESSARY UNLESS OTHERWISE NOTED:

PHYSICIANS NAME:_____ **PHONE:**_____

PHYSICIANS SIGNATURE:_____ **DATE:**_____