DME PRESCRIPTION ☆ ☆

PATIENTS NAME: _____ **Tel. No. ( )** _____
D.O.B __/__/____ **Social Security:** ___-__-____
DIAGNOSIS CODES: _____

BRACING	POST SURGICAL BRACES	MEDICAL NECESSITY
Upper: ☐ **Cervical Collar Soft / Rigid** ☐ **Arm Sling Size: One size fits all** ☐ **Elbow Brace(Hinged) L/R Size: XS S M L XL** ☐ **Wrist Hand Orthosis L/R Size:One size fits all** ☐ **Wrist Brace L/R Size: XS/ One size fits all** ☐ **Thumb Spica L/R: Size: One size fits all** ☐ **Long** ☐ **Short** ☐ **Industrial Back Support Size: One size fits all** **Lower:** ☐ **Lumbar Spine Support:One size fits all** ☐ **Knee brace(Hinged) L/R Size: XS S M L XL XXL** ☐ **Knee Support L/R Size: XS S M L XL XXL** ☐ **Ankle Brace L/R Size: One size fits all** ☐ **AFO Brace L/R Size: One size fits all** ☐ **Arch Supp/Foot Orthosis: Shoe Size**____	☐ **Shoulder Immobilizer Size:** ____ ☐ **Elbow Hinged Brace Size:** ____ ☐ **LBO Back Brace Size:** ____ ☐ **Hinged Knee Brace L/R Size:** ____ ☐ **Shoulder Sling With Pillow Size:** ____ ☐ **Walker Boot Size:** ____	☐ Manage Pain ☐ Restrict ROM ☐ Limit ROM ☐ Stabilize Joint ☐ Protect Joint ☐ Protect Surgical Repair ☐ Increase ROM ☐ Other: _____

HOT & COLD UNIT WITH PUMP ☐ POST SURGICAL	MEDICAL NECESSITY
☐ Motorized Hot & Cold Unit ☐ **Purchase** ☐ **Rental 12 month** ***Reason:*** ☐ Lumbar ☐ Knee ☐ Cervical / Shoulder ☐ PTP/STP-Recommended on going care ☐ Wrist ☐ Hip ☐ Foot / Ankle ☐ Chronic Pain	☐ Manage Pain ☐ Reduce Swelling ☐ Help in Rehab Process ☐ Post-Surgical Rehab ☐ Relax Muscle Spasms ☐ Other: _____

ELECTROTHERAPY ☐ POST SURGICAL	MEDICAL NECESSITY
☐ Prime Interferential Therapy **(IF 4000)** ☐ **Purchase** ☐ **Rental 12 month** (with supplies for period of medical necessity) ***Reason:*** ☐ PTP/STP-Recommended on going care ☐ Chronic Pain ☐ Prime Dual Electrical Stimulator **(TENS -EMS)** (with supplies for period of medical necessity) **Conductive Garment:** ☐ **Wrist** ☐ **Elbow** ☐ **Knee Sleeves** ☐ **Ankle** ☐ **Back** ☐ **Shoulders**	☐ Manage / Reduce Pain ☐ Improve Circulation ☐ Increase ROM ☐ Expedite Recovery ☐ Relax Muscle Spasms ☐ Post OP Pain ☐ Reduce Swelling ☐ Reduce Edema ☐ Re-educate Muscle ☐ Prevent Atrophy ☐ Other: _____

TRANSDERMAL GEL/PATCHES	MEDICAL NECESSITY
☐ Menthoderm Gel 240 gm Refills_____ ☐ Terocin Patch #30 (Menthol 4%/Lidocaine 4%)	☐ Manage / Reduce Pain

HOME EXERCISE KITS	MEDICAL NECESSITY
Upper Body: ☐ Cervical/Neck ☐ Shoulder ☐ Hand/Wrist ☐ Elbow Lower Body: ☐ Lumbar ☐ Knee ☐ Foot/Ankle	☐ Increase Strength ☐ Manage/Reduce pain ☐ Increase ROM ☐ Expedite Recovery ☐ Reduce Swelling

TRACTION UNITS	BONE GROWTH STIMULATOR	MEDICAL NECESSITY
☐ Traction Unit ☐ Cervical Pump ☐ Other: _____	☐ Long Bone ☐ Non-union Fracture ☐ Spine ☐ Adjunct to Spinal Fusion ☐ Failed Fusion	☐ Manage Pain ☐ Reduce Swelling ☐ Help in Rehab Process ☐ Post Surgical Rehab ☐ Relax Muscle Spasms ☐ Other: _____

WALKING AIDS	PILLOWS / CUSHIONS	SPECIAL REQUEST
☐ Cane Regular / Quad ☐ Crutches Size: S M L XL ☐ Front Wheeled Walker ☐ Walker with Brakes/Seat	☐ Back Cushion ☐ Donut Cushion ☐ Cervical Pillow Full / Wrap Around ☐ Wedge Pillow	☐ Power uplift seat ☐ Three in One Commode ☐ Shower Chair

ESTIMATED LENGTH OF NEED FOR DME EQUIPMENT ☐ 3 TO 12 MONTHS

PHYSICIAN'S INFORMATION

Deliver to: Physician's Office Patient's Home Address Dispense at Physician's office
Physician's Name _____ _____ Date: _____

Physician's Signature: _____ _____ Date: _____

Based on the patient's condition, symptoms and diagnosis, and in compliance with title 8, California code of regulations 4600(B), I hereby notify that the prescribed Durable Medical Equipment is medically necessary to relieve patient's symptoms caused by his or her condition.