# Physician Order Form

ORTHOTIC BRACE

Patient's Name _____ Start Date _____

Address _____ City _____ State _____ Zip _____

HT: _____ WT: _____ DOB: _____

Insurance # 1 _____ Insurance # 2 _____

## BRACES / CRUTCHES

- ☐ Tru-Pull Knee DJO (L1810)
- ☐ Hinged Knee Brace (L1810)
- ☐ Hinged Air DJO (L1833)
- ☐ Crutches - Pair (E0114)
- ☐ Crutch - Single (E0116)
- ☐ Other _____

## HAND / ANKLE / SHOULDER / CERVICAL

- ☐ Boot Walker Air Low BH (L4360)
- ☐ Boot Walker Air Tall BH (L4360)
- ☐ AFO-RT BH (L1930)
- ☐ AFO-LT BH (L1930)
- ☐ Clavicle Support BH (L3960)
- ☐ Plantar Fascitis Support BH (L1902)
- ☐ Shoulder Immob BH (L3650)
- ☐ Shoulder Ultra Sling DJO (L3960)
- ☐ Pneumatic Walking Boot Tall / Short, RT / LT
- ☐ Other _____

Diagnosis ☐ _____

***Qualifications and required documentation to be noted in Face to Face chart notes from Physician.**

LENGTH OF NEED _____

ADDITIONAL COMMENTS _____

Physician or FNP Name _____ NPI # _____

Address _____ City _____ State _____

Zip _____ Phone _____ Fax _____

Physician or FNP Signature _____ Date _____