



PHYSICIAN WRITTEN ORDER & CERTIFICATE OF MEDICAL NECESSITY - ANFT

Corporate Headquarters: 770 Ritchie Highway, Suite W-21 Severna Park, MD 21146

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www.dynasplint.com

FAX TO: _____

PATIENT INFORMATION	Start Date of Order (MM/DD/YY) _____	Date of Birth _____	Date of Onset/Surgery/Injury _____
	First Name _____	Last Name _____	

DYNASPLINT® SYSTEM(S) PRESCRIBED	<input type="radio"/> Ankle Dynasplint®	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right Limb	<input type="radio"/> Left Limb
	<input type="radio"/> Ankle Dynasplint® w/Shoe	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right Limb	<input type="radio"/> Left Limb
	<input type="radio"/> MTP Dynasplint®	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right Limb ○1○2○3○4○5	<input type="radio"/> Left Limb ○1○2○3○4○5
	<input type="radio"/> MTP Dynasplint® w/Shoe	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right Limb ○1○2○3○4○5	<input type="radio"/> Left Limb ○1○2○3○4○5
	<input type="radio"/> Hammer Toe Dynasplint®	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right Limb ○1○2○3○4○5	<input type="radio"/> Left Limb ○1○2○3○4○5
	<input type="radio"/> Hammer Toe Dynasplint® w/Shoe	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right Limb ○1○2○3○4○5	<input type="radio"/> Left Limb ○1○2○3○4○5
	<input type="radio"/> Hallux Varus Dynasplint®	<input type="radio"/> Adduction	<input type="radio"/> Abduction	<input type="radio"/> Right Limb ○1○2○3○4○5	<input type="radio"/> Left Limb ○1○2○3○4○5
	<input type="radio"/> Hallux Valgus Dynasplint®	<input type="radio"/> Adduction	<input type="radio"/> Abduction	<input type="radio"/> Right Limb ○1○2○3○4○5	<input type="radio"/> Left Limb ○1○2○3○4○5
	<input type="radio"/> External Fixator			<input type="radio"/> Right Limb	<input type="radio"/> Left Limb

ATTACHMENTS/ ACCESSORIES	<input type="radio"/> MPO 2000 Active® Ankle-Foot Orthosis	<input type="radio"/> DS1971 Ankle Inversion/Eversion Control System
	<input type="radio"/> Darco® Shoe (for use with Ankle Dynasplint® System)	<input type="radio"/> Other _____

OTHER INFO	SPECIAL FITTING INSTRUCTIONS:
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DIAGNOSIS	<input type="radio"/> Hallux Varus	<input type="radio"/> Joint Implant	<input type="radio"/> Hammer Toe	<input type="radio"/> Achilles Tendonitis
	<input type="radio"/> Hallux Valgus	<input type="radio"/> Bunionectomy	<input type="radio"/> Plantar Fasciitis	<input type="radio"/> Rear Foot Reconstruction
	<input type="radio"/> Joint Contracture	<input type="radio"/> Cheilectomy	<input type="radio"/> Heel Spur	<input type="radio"/> Other _____

ROM	<input type="radio"/> Other _____	CURRENT	GOAL
	<input type="radio"/> Dorsiflexion	_____	_____
	<input type="radio"/> Plantar Flexion	_____	_____

LENGTH OF NEED	<input type="checkbox"/> 1 Month	<input type="checkbox"/> 3 Months	<input type="checkbox"/> 6 Months	<input type="checkbox"/> Other: _____
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PHYSICIAN INFORMATION AND SIGNATURE	Physician's Name (PLEASE PRINT) _____		Phone Number _____	
	NPI Number _____		Fax Number _____	
	Street Address _____	City _____	State _____	Zip Code _____

NO SUBSTITUTIONS ALLOWED – In my opinion, in accordance with accepted medical practice standards, the above named patient requires the exact Dynasplint® System(s) as dispensed by Dynasplint Systems, Inc., for the diagnosis indicated.

SIGN AND DATE →

Physician's Signature _____	DATE / / _____
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FAX TO	This form is needed to bill the patient's insurance. Please complete and return.	SALES CONSULTANT _____	PHONE _____	e-FAX _____
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