



PHYSICIAN WRITTEN ORDER & CERTIFICATE OF MEDICAL NECESSITY - ORTHO

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

Phone: 800.638.6771 / 410.544.9530

www.dynasplint.com

FAX TO:

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

DYNASPLINT SYSTEM(S) PRESCRIBED
Shoulder, Elbow, Forearm, Wrist, Carpal Tunnel, Hand (MCP), Finger, Knee, Ankle, Toe, Hammer Toe
Internal Rotation, External Rotation, Extension, Supination, Dorsiflexion, Varus
Elevation, Flexion, Flexion, Plantar Flexion, Plantar Flexion, Valgus
Right, Left, Right, Left, Right, Left, Right, Left, Right, Left, Right, Left
0 1 0 2 0 3 0 4 0 5

ATTACHMENTS OR ACCESSORY ITEM(S)
ACCESSORY ITEMS: Resting Hand/Wrist Orthosis, MPO 2000 Active Ankle-Foot Orthosis, Darco Shoe, Soft Padded Shoe, DS1971 Inversion/Eversion Control System, Replacement Cuffing Kit
WRIST DYNASPLINT SYSTEM HANDPIECE ATTACHMENTS (SELECT ONE): Hand Pan "C" Cup Attachment, Padded Palmar Hand Attachment, Universal Flat Piece Hand Attachment, Mitt Splint Hand Attachment, Anti-Spasticity Ball Hand Attachment

ROM: _____

DIAGNOSIS
Primary Diagnosis/ICD-9 Code (PLEASE PROVIDE PATIENT CHART NOTES RELATED TO THIS DIAGNOSIS.)
Date of Onset/Surgery/Injury
Secondary Diagnosis/ICD-9 Code (PLEASE PROVIDE PATIENT CHART NOTES RELATED TO THIS DIAGNOSIS.)
Date of Onset/Surgery/Injury

LENGTH OF NEED
1 Month, 3 Months, 6 Months, Other: _____

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

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