

# DETAILED WRITTEN ORDER

PATIENT INFORMATION	Start Date of Order (MM/DD/YY) _____		Date of Birth _____		
	First Name _____		Last Name _____		
DYNASPLINT® SYSTEM(S) PRESCRIBED	<input type="radio"/> Jaw				
	<input type="radio"/> Shoulder	<input type="radio"/> Internal Rotation <input type="radio"/> External Rotation	<input type="radio"/> Elevation <input type="radio"/> Flexion	<input type="radio"/> Right <input type="radio"/> Left	
	<input type="radio"/> Elbow	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right <input type="radio"/> Left	
	<input type="radio"/> Forearm	<input type="radio"/> Supination	<input type="radio"/> Pronation	<input type="radio"/> Right <input type="radio"/> Left	
	<input type="radio"/> Wrist	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right <input type="radio"/> Left	
	<input type="radio"/> Carpal Tunnel				
	<input type="radio"/> Hand (MCP)	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right <input type="radio"/> Left	
	<input type="radio"/> Finger	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	
	<input type="radio"/> Knee	<input type="radio"/> Extension	<input type="radio"/> Flexion	<input type="radio"/> Right <input type="radio"/> Left	
	<input type="radio"/> Ankle	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right <input type="radio"/> Left	
	<input type="radio"/> Toe	<input type="radio"/> Dorsiflexion <input type="radio"/> Varus	<input type="radio"/> Plantar Flexion <input type="radio"/> Valgus	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	
	<input type="radio"/> Hammer Toe	<input type="radio"/> Dorsiflexion	<input type="radio"/> Plantar Flexion	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	
	<input type="radio"/> External Fixator				
ATTACHMENTS OR ACCESSORY ITEM(S)	<b>ACCESSORY ITEMS</b> <input type="radio"/> Resting Hand/Wrist Orthosis <input type="radio"/> RestAir™ Hip Orthosis <input type="radio"/> Kentucky Kollar <input type="radio"/> NeuroFlex™ Restorative™ Knee Orthosis <input type="radio"/> NeuroFlex™ Restorative™ Elbow Orthosis <input type="radio"/> MPO 2000 Active® Ankle-Foot Orthosis <input type="radio"/> Darco® Shoe (for use with Ankle Dynasplint® System) <input type="radio"/> Soft Padded Shoe (for use with Toe Dynasplint® Systems) <input type="radio"/> DS1971 Inversion/Eversion Control System <input type="radio"/> Replacement Soft Interface Material		<b>WRIST DYNASPLINT® SYSTEM HANDPIECE ATTACHMENTS (SELECT ONE)</b> <input type="radio"/> Hand Pan "C" Cup Attachment <input type="radio"/> Padded Palmar Hand Attachment <input type="radio"/> Universal Flat Piece Hand Attachment <input type="radio"/> Mitt Splint Hand Attachment <input type="radio"/> Anti-Spasticity Ball Hand Attachment		
	ROM: _____		FREQUENCY OF USE: _____		
DIAGNOSIS	Primary Diagnosis Code (PLEASE PROVIDE PATIENT CHART NOTES RELATED TO THIS DIAGNOSIS.) _____		Date of Onset/Surgery/Injury _____		
	Secondary Diagnosis Code (PLEASE PROVIDE PATIENT CHART NOTES RELATED TO THIS DIAGNOSIS.) _____		Date of Onset/Surgery/Injury _____		
LENGTH OF NEED	<input type="radio"/> 1 Month <input type="radio"/> 3 Months <input type="radio"/> 6 Months <input type="radio"/> 12 Months <input type="radio"/> Lifetime <input type="radio"/> Other: _____				
PHYSICIAN INFORMATION AND SIGNATURE	Physician's Name (PLEASE PRINT) _____		Phone Number _____		
	NPI Number _____		Fax Number _____		
	Street Address _____		City _____	State _____	Zip Code _____
	<i>I certify that I am the treating physician identified on this detailed written order. I have received this completed detailed written order and agree with prescribing the items listed. This detailed written order has been reviewed and signed by me and I certify that all information is true and accurate to the best of my knowledge.</i>				
SIGN AND DATE	Physician's Signature _____		Date _____		

**NOTE: Signature and Date Stamps are Not Acceptable.**