PHYSICIAN WRITTEN ORDER & CERTIFICATE OF MEDICAL NECESSITY

Corporate Headquarters: 770 Ritchie Highway, Suite W-21 Severna Park, MD 21146-3923
Phone: 800.638.6771 / 410.544.9530 www.dynasplint.com

Dynasplint® Systems aid in restoring physical function to patients with joint stiffness and limited range of motion. The key to its effectiveness is the low-load, prolonged-duration stretch (LLPS) that delivers a correct biological stimulus to create a permanent length change in shortened connective tissue. Dynasplint® Systems have been clinically proven to reduce time and cost associated with range of motion rehabilitation – in many cases by more than 50 percent.

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Start Date of Order (MM/DD/YY) _____

DYNASPLINT® SYSTEM(S) PRESCRIBED

SELECT JOINT(S)

- ❒ Shoulder
- ❒ Elbow
- ❒ Supination/Pronation [Forearm]
- ❒ Wrist
- ❒ Carpal Tunnel
- ❒ MCP-Hand
- ❒ PIP-Finger
- ❒ Knee
- ❒ Ankle
- ❒ MTP- Toe
- ❒ MTP- Toe w/ Shoe
- ❒ Trismus

SELECT DIRECTION(S)

- ❒ Flexion
- ❒ Extension
- ❒ Dorsiflexion
- ❒ Plantar Flexion
- ❒ Supination
- ❒ Pronation
- ❒ Internal Rotation
- ❒ External Rotation

SELECT TYPE(S)

- ❒ Infant
- ❒ Pediatric
- ❒ Youth
- ❒ Adult
- ❒ Neurological
- ❒ External Fixator
- ❒ BKA

SELECT SIDE(S)

- ❒ Right Limb
- ❒ Left Limb
- ❒ Bilateral

ATTACHMENTS OR ACCESSORY ITEM(S)

ACCESSORY ITEMS

- ❒ Resting Hand/Wrist Orthosis
- ❒ MPO 2000® Active Control Boot
- ❒ Hip Abduction Pillow
- ❒ Darco® Shoe (for use with Ankle Dynasplint® System)
- ❒ Other:_____

WRIST DYNASPLINT® SYSTEM HANDPIECE ATTACHMENTS

- ❒ Hand Pan "C" Cup Attachment
- ❒ Padded Palmar Hand Attachment
- ❒ Universal Flat Piece Hand Attachment
- ❒ Mitt Splint Hand Attachment
- ❒ Anti-Spasticity Ball Hand Attachment

DIAGNOSIS

Diagnosis *[Please provide patient chart notes related to this diagnosis.]* _____

Date of Onset/Surgery/Injury _____ ICD-9 Code _____

CURRENT ROM

❒ ROM _____

LENGTH OF NEED

❒ 1 Month ❒ 3 Months ❒ 6 Months ❒ Lifetime ❒ Other: _____

PHYSICIAN INFORMATION & SIGNATURE

Physician's Name [Please Print] _____ Phone Number _____

NPI/UPIN 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.

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** _____

Stretch Beyond Your Expectations.®