STANDARD WRITTEN ORDER

PATIENT INFORMATION

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

_____
Date of Birth

_____
First Name

_____
Last Name

DYNASPLINT® SYSTEM(S) PRESCRIBED

- ○ Jaw
- ○ Shoulder
  - ○ Internal Rotation   ○ Elevation
  - ○ External Rotation   ○ Flexion
  - ○ Right   ○ Left
- ○ Elbow   ○ Extension   ○ Flexion   ○ Right   ○ Left
- ○ Forearm   ○ Supination   ○ Pronation   ○ Right   ○ Left
- ○ Wrist   ○ Extension   ○ Flexion   ○ Right   ○ Left
- ○ Carpal Tunnel   ○ Right   ○ Left
- ○ Hand (MCP)   ○ Extension   ○ Flexion   ○ Right   ○ Left
- ○ Finger   ○ Extension   ○ Flexion
  - ○ Right   ○ Left
  - ○1 ○2 ○3 ○4 ○5   ○1 ○2 ○3 ○4 ○5
- ○ Knee   ○ Extension   ○ Flexion   ○ Right   ○ Left
- ○ Ankle   ○ Dorsiflexion   ○ Plantar Flexion   ○ Right   ○ Left
- ○ Toe
  - ○ Dorsiflexion   ○ Plantar Flexion   ○ Right   ○ Left
  - ○ Varus   ○ Valgus
  - ○1 ○2 ○3 ○4 ○5   ○1 ○2 ○3 ○4 ○5
- ○ Hammer Toe   ○ Dorsiflexion   ○ Plantar Flexion
  - ○ Right   ○ Left
  - ○1 ○2 ○3 ○4 ○5   ○1 ○2 ○3 ○4 ○5
- ○ External Fixator   ○ Right   ○ Left

ATTACHMENTS OR ACCESSORY ITEM(S)

ACCESSORY ITEMS
- ○ Resting Hand/Wrist Orthosis
- ○ BendEase Hand
- ○ NeuroFlex™ Restorative™ FlexHand
- ○ NeuroFlex™ Restorative™ Elbow Orthosis
- ○ Kentucky Kollar
- ○ RestAir™ Hip Orthosis

- ○ NeuroFlex™ Restorative™ Knee Orthosis
- ○ MPO 2000 Active® Ankle-Foot Orthosis
- ○ Safeboot
- ○ Soft Padded Shoe (for use with Toe Dynasplint® Systems)
- ○ Dynamic Control Boot
- ○ DS1971 Inversion/Eversion Control System
- ○ Replacement Soft Interface Material

WRIST DYNASPLINT® SYSTEMS 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
- ○ Progressive Hand Attachment

FIT

○ Personalized Fitting

ROM

ROM: _____   Frequency of Use: _____ Time(s) Daily / _____ Hour(s) Per Day

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

○1 Month   ○3 Months   ○6 Months   ○12 Months   ○Lifetime   ○Other: _____

PHYSICIAN INFORMATION AND SIGNATURE

Physician's Name   *(PLEASE PRINT)*
Phone Number

NPI Number
Fax Number

Street Address   City   State   Zip Code

I certify that I am the treating physician identified on this standard written order. I have received this completed standard written order and agree with prescribing the items listed. This standard 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.

SIGN AND DATE ►

_____
Physician's Signature   *NOTE: Signature and Date Stamps are Not Acceptable.*

____ / ____ / ____
Date