# CONDITION STATEMENT FOR KNEE ORTHOSIS

CLIENT NAME: _____ MEDICARE ID: _____

DATE OF BIRTH: ____/____/____ HEIGHT: ____" WEIGHT: _____ lbs.

ADDRESS: _____

TELEPHONE: (____) _____-_____

LAST EXAMINATION DATE: _____

DIAGNOSES CODES AND CONDITIONS THAT SUPPORT THE MEDICAL NECESSITY FOR A KNEE ORTHOSIS/BRACE (KO) INCLUDING THE FLEXION OR EXTENSION CONTRACTURE OF THE KNEE WITH MOVEMENT ON A PASSIVE RANGE OF MOTION TESTING OF AT LEAST 10 DEGREES, SITE OF SWELLING, DIAGNOSIS, TREATMENT OPTIONS AND PLAN OF CARE FOR KNEE PAIN MANAGEMENT:

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SPECIFICATIONS REQUIRED:

Circle One: Single Pivot Hinge Dual Pivot Hinge ROM – Range of Motion Hinge Other: _____

EXPECTED LENGTH OF TIME PATIENT WILL REQUIRE (KO) KNEE ORTHOSIS:

Months Needed _____ (99 = Lifetime)

_____

_____

_____

**OFFICE** (____) _____ **FAX** (___) _____

PHYSICIAN OR TREATING PRACTITIONER'S SIGNATURE: _____

DATE SIGNED: _____ NPI: _____