Detailed Written Order

fax: 281-752-4019

form GMI1904

Last Name _____ First Name _____ Date of Birth _____

Email _____ Phone # _____ Cell/Alternate # _____

Address _____ City _____ State _____ Zip _____

Primary Insurance _____ ID # _____ Secondary _____ ID # _____

Spine

waist size _____ height _____ weight _____

arthrosis - lumbar / thoracic (M47.817 / M47.814)
degenerative disc disease (M51.36)
disc displacement - cervical / lumbar / thoracic (M50.2 / M51.26 / M51.84)
fracture - cervical / lumbar / thoracic (S12.9XXA / S32.0008A / S22.009A)
kyphosis / scoliosis (M40.00 / M41.00)
radiculitis (M54.16)
stenosis - lumbar / thoracic (M48.06 / M48.04)
strain - lumbar / thoracic (S33.5XXA / S23.3XXA)

other _____

L0457 Thoracic Lumbar ☐

L0650 Lumbar Support (with lateral stability) ☐

L0648 Lumbar Support ☐

L0180 Cervical ☐

Knee

Left **Right**

circum. at mid patella _____

6" above mid patella _____

cartilage tear (S83.502A, S83.501A)
edema (R60.1)
instability (M23.52, M23.51)
internal derangement (M23.92, M23.91)
ligament disruption (M23.602, M23.601)
osteoarthritis (M17.12, M17.11)
sprain (S83.8X2A, S83.8X1A)

other _____

L4370 Cryo-Pneumatic ☐

L1833 Hinged Knee + L2397 Sleeve ☐ ☐

Post-Op Soft Wrap

L1851 OA Knee + L2397 Sleeve ☐

L1852 Ligament Brace + L2397 Sleeve ☐

Ankle & Foot

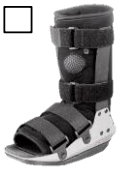
Left **Right**

shoe size _____

achilles bursitis (M76.62, M76.61)
foot drop (M21.372, M21.371)
fracture (S84.375A, S84.374A)
instability (M24.872, M24.871)
plantar fibromytosis (M72.2)
sprain (S93.401A, S93.401A)

other _____

L4361 Walker ☐



L2114 Fracture Boot ☐

L4397 Night Splint ☐

L1971 Anlke Support ☐

L1932 Foot Drop Splint ☐

Upper Extremity

Left **Right**

carpal tunnel syndrome (G56.02, G56.01)
dislocation - elbow / shoulder (M24.822, M24.821 / Z96.612, Z96.611)
osteoarthritis - hand / elbow (M19.032, M19.031 / M19.022, M19.021)
rotator cuff tear (M75.122, M75.121)
sprain - wrist (S63.502, S63.501)

other _____

L3960 Shoulder Immobilizer ☐

L3760 Elbow Support ☐

L3816 Wrist/Hand ☐

L3809 Wrist ☐

I certify that the patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and other supporting documentation will be provided upon request. I also certify that I am the treating practitioner identified on this form and have reviewed this Detailed Written Order. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Start Date _____ Duration of Need _____ Prognosis _____

Printed Name of MD, DO, PA, NP, or APRN _____ NPI _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

☐ Product Selection Permitted

Signature of MD, DO, PA, NP, or APRN _____ **Date** _____