PRESCRIPTION & ORDER FORM Bone Growth Stimulator Prescription

Patient Name: _____ Phone: _____

Address: _____ DOB: _____ SS#: _____

City: _____ State:_____ Zip: _____

Prescriber's Full Name: _____ NPI #: _____

Practice Name: _____ Phone #:_____ Fax#: _____

Address: _____ City: _____ State: _____ Zip:_____

INSURANCE INFORMATION

Primary Insurance:_____ Secondary Insurance: _____

Name of Insured: _____ Name of Insured: _____

Insured SSN#: _____ DOB: _____ Insured SSN#: _____ DOB: _____

Insurance Carrier Address:_____ Insurance Carrier Address:_____

City: _____ State:_____ Zip:_____ City: _____ State:_____ Zip:_____

Policy/Claim #: _____ Policy/Claim #: _____

ID#:_____ Group#: _____ ID#:_____ Group#:_____

Insurance Co Phone: _____ Insurance Co Phone: _____

Contact: _____ Contact: _____

Employer: _____ Employer: _____

MEDICAL SUMMARY

ICD10 Diagnosis Codes: _____ Diagnosis (Description): _____ Order Date: _____

Diagnosis: (check all that apply)
- ☐ Degenerative Disc Disease
- ☐ Internal Disc Disruption
- ☐ Herniated Nucleus Pulposus
- ☐ Pseudoarthrosis (Failed Fusion)
- ☐ Other: _____

Risk Factors: (check all that apply)
- ☐ Multi-Level Fusion ☐Obesity ☐Previous Spine Surgery
- ☐ Mixed Graft ☐Osteoporosis ☐Smoking/Nicotine
- ☐ Bone Depleting Disease ☐ Bone Depleting Medication
- ☐ Diabetes ☐ Pseudoarthrosis (Failed Fusion)
- ☐ Revision to a Failed Fusion ☐ Steroid Use ☐ Alcoholism
- ☐ Spondylolisthesis (Grade) _____

Type of Bone Growth Stimulator Prescribed:
- ☐ Orthofix Spinal-Stim©
- ☐ Orthofix Cervical-Stim ©
- ☐ DJO Spinalogic © *

- By signing below, I the Prescribing Physician understand the Food and Drug Administration has approved the Spinalogic Bone Growth Stimulator (DJO Spinalogic) to use as an adjunct treatment for primary lumbar fusion surgery for one or two levels. I acknowledge that DME Medical Supply has not promoted the DJO Spinalogic for any other use or otherwise encouraged me to order it for any other use. I specifically desire to order the DJO Spinalogic so that I may treat the patient named above according to my informed medical judgment.

Please Read and Sign Below (Please retain a copy of this prescription): I am the treating physician/practitioner identified above. The information contained above is true, accurate and complete, to the best of my knowledge. Due to my diagnosis of the patient, I am ordering a bone growth stimulator. DME Medical Supply Specialist is providing a bone growth stimulator. In my medical judgment, this device is medically necessary. For Medicare beneficiaries this is my preliminary written order; I understand a detailed written order (CMS 847) will be required.

Prescriber Signature: _____ **Date:** _____