ORTHOPEDIC ORDER

Patient Name: _____ **DOB:** _____

Address: _____ **Phone #:** _____

Insurance ID #: _____

Check all that apply:

KNEE
- □ Hinged Brace w/ Adjustable Joints, Prefab
- □ Hinged Brace w/ Adjustable Joints, Custom
- □ Soft Interface, below knee, 2 per leg
- □ Soft Interface, above knee, 2 per leg
- □ Non-corrosive Finish, 2 per leg
- □ Condylar Pad, 2 per leg
- □ Suspension Sleeve, 2 per leg

BACK
- □ Lumbar-Sacral Brace, sagittal-coronal control, w/ rigid anterior + posterior panels, straps and closures

ANKLE
- □ Ankle Control Brace
- □ AFO Brace

WRIST
- □ Wrist Brace, without joints

ELBOW
- □ Elbow Brace w/ locking joints

FOOT
- □ CAM Walking Boot, pneumatic
- □ Foot Drop Splint
- □ Diabetic Shoes, 1 for each foot
- □ Diabetic Inserts, foam, 3 for each shoe

SHOULDER & NECK
- □ Shoulder Brace, acromio/clavicular
- □ Cervical Collar, semi-rigid , thoracic

HERNIA
- □ Truss, double w/ standard pad

OTHER (fill out):

Circle if applicable: **LEFT** **RIGHT**

DIAGNOSIS/ICD-10 CODE(S): _____

Prescriber Name: _____ **NPI:** _____

Office Address: _____ **Phone #:** _____

Prescriber Signature: _____ **Date:** _____

INLAND
DURABLE MEDICAL EQUIPMENT
& MEDICAL SUPPLY

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