Atlas
PROSTHETICS & ORTHOTICS

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Please complete form in its entirety and include physician chart notes pertaining to the patient's orthotic and/or prosthetic needs, demographics and insurance information.

Patient Name: _____ DOB: _____ Date: _____
Address: _____ City_____ State_____ Zip_____
Diagnosis/ICD-10 Codes: _____

Rx ☐ Right ☐ Left ☐ Bilateral

☐ Custom Device	☐ Custom fit Off-the-Shelf Device*

*The prescribed device and/or supply is to be evaluated for and custom fit by a certified/licensed O & P professional.

Prognosis: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Duration of Need: ☐ 2 Weeks ☐ 4 Weeks ☐ 90 Days ☐ 6 Months ☐ 1 Year ☐ Lifetime

For Prosthetics:
☐ K1 - Transfer/Household Fixed Cadence Ambulator
☐ K2 - Limited Community Ambulator
☐ K3 - Community Ambulator with Variable Cadence
☐ K4 - Highly Active Ambulator

I certify that the above recommendation and any repair and/or parts to maintain proper fit and function are appropriate for this patient and are deemed medically necessary.

_____ Physician Signature (**stamps not approved**)
_____ Date

_____ Printed Physician Name and Credentials
_____ NPI #

_____ Address
_____ Telephone

_____ City, State, Zip Code
_____ Fax

Please send completed information to: info@atlaspo.com or fax to (281) 602-3451