Rehab Services, LLC
100 Cathedral Street, Suite 2 • Annapolis, MD 21401
Phone/Fax: 800.486.5633 • rsmedco.com

Patient Name: _____

Date of Birth: _____

Surgery Date: _____

ICD-10 Codes: _____

EQUIPMENT WARRANTY INFORMATION FORM

Every product sold or rented by our company carries a manufacturer's warranty. Rehab Services or its business partners will notify all beneficiaries of the warranty coverage and will honor all warranties under applicable law. Rehab Services or its business partners will replace, free of charge, equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available. I have been instructed and understand the warranty coverage on the product I have received. By signing below, I am in agreement with the equipment warranty information.

PATIENT ACKNOWLEDGE & AUTHORIZATION ASSIGNMENT OF BENEFITS (PA/AOB)

I acknowledge either receipt of the DVT device directly from my doctor's office OR that the DVT device has been prescribed and will be shipped directly to my residence. I request that payment of authorized insurance be made on my behalf to Rehab Services or its business partners for products and services they provide to me. I further authorize a copy of this agreement to be used in place of the original to release to payers any information needed to determine these benefits or compliance with current healthcare standards. I understand that I am financially responsible for my health insurance deductible, coinsurance, co-payments or non-covered services. I acknowledge receiving instruction, have demonstrated or verbalized by understanding in the proper use and care of equipment or supplies received today described on this document, and will follow them. I acknowledge receipt and understand the company patient information privacy notice and that all information on this document is correct.

Patient or Responsible Party Signature: _____

Date: _____ Relationship to Patient: _____

STATEMENT OF MEDICAL NECESSITY

The patient will be incapacitated after surgery and in order to stimulate blood circulation, decrease swelling and inflammation, and reduce the chances of DVT. I am prescribing an intermittent Limb Compression device for homecare use. I have evaluated this patient and it is my opinion they should not take pharmacologic agents. I have prescribed a DVT compression as an alternative to any pharmacologic anticoagulant. I consider this form of mechanical prophylaxis to be an equally effective protocol in the postoperative prevention of a DVT or PE event, without the bleeding and other potential risks and contraindications so frequently associated with blood thinners.

Due to the reduced physical activity of my patient following surgery, this DVT compression device has been prescribed following my care guidelines. In accordance with these guidelines, the intermittent pneumatic compression with extremity pump is clinically indicated for deep venous thrombosis prevention for immobile patients. I certify that this DVT device I am prescribing is medically necessary to treat the specific medical condition described in the attached medical records and is not for general good health or cosmetic purposes. I also certify that the devices will assist my patient to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of my patient and those functional capacities that are appropriate for individuals of the same age.

Physician Signature: _____

Physician Name: _____

Date: _____ NPI #: _____

EQUIPMENT – HOME USE

☐ E0676 - DVT/Intermittent Limb Compression Device ☐ DVT Extender

Please place product sticker here.

DVT RISK ASSESSMENT - Add up patient points at the bottom

RISK FACTOR	POINT VALUE	POINTS
Age 40 – 59	1	
Age 60 – 74	2	
Age 75 and Older	3	
BMI > 30	1	
BMI > 40	2	
BMI > 50	3	
Medical Patient at Bed Rest	1	
Leg Plaster Cast or Brace	1	
Pregnancy or Postpartum <1 Month	1	
Abnormal Pulmonary Function	1	
Oral Contraceptives	1	
Hormone Therapy	1	
Swollen Legs	1	
Current Smoker	1	
Varicose Veins	1	
Prior Major Surgery <1 Month	1	
Use of Tourniquet	1	
General Anesthesia >30 Minutes	2	
Major Surgery >60 Minutes	2	
Arthroscopic Surgery	2	
Laparoscopic Surgery >60 Minutes	2	
Major Surgery Lasting 2 – 3 Hours	3	
Major Surgery More Than 3 Hours	5	
History of DVT/PE	3	
Family History of DVT/PE	3	
Elective Lower Extremity Arthroplasty	5	
Hip, Pelvis, Leg Fracture <1 Month	5	
Multiple Trauma <1 Month	5	
PATIENT RISK SCORE TOTAL		

Please fax to 800.486.5633 or email shawn@rsmedco.com