



Rehab Services, LLC
100 Cathedral Street, Suite 2
Annapolis, MD 21401

Phone/Fax: 800.486.5633
RSmedco.com

NPI: 1487696852

Wrist Brace

Physician Order, Prescription and Certificate of Medical Necessity

Patient Name: _____ Date of Order: _____

Patient Date of Birth: _____

Patient Phone Number(s): _____

Primary Diagnosis Code or Description: _____

Side: ☐ Left ☐ Right ☐ Bilateral

Size	Dimension Around the Wrist
<input type="checkbox"/> X-Small	5.0" - 5.5"
<input type="checkbox"/> Small	5.5" - 6.3"
<input type="checkbox"/> Medium	6.3" - 7.0"
<input type="checkbox"/> Large	7.0" - 8.0"
<input type="checkbox"/> X-Large	8.0" - 10"

Notes: _____

By signing below, I deem this Medical Device listed above to be medically necessary and prescribe it to be provided at home for the patient listed.

Physicians Signature: _____ Date: _____

Physicians Printed Name: _____

Fax to 800.486.5633. Please include Patient Demographic Sheet.