

Patient Name: _____

Surgery Date: _____

Surg Procedure: _____

Body Part: _____



MEDICAL SOLUTIONS

Rep:

Cell: () -

Fax: () -

Written Order / Prescription / DVT Risk Assessment

ICD Codes: _____ X _____ X _____ X _____ X _____

<input type="checkbox"/> DVT Prophylaxis Unit with Intermittent Limb Therapy (RENTAL)	<input type="checkbox"/> Pneumatic Knee Orthosis.....L1833
Required: _____ Days	<input type="checkbox"/> Freedom leg.....L2136
<input type="checkbox"/> DVT Prophylaxis Unit with Intermittent Limb Therapy (PURCHASE)	<input type="checkbox"/> Underarm Spring Assisted Crutch.....E0117 x 2
<input type="checkbox"/> Other: _____	<input type="checkbox"/> A - Frame / Aluminum Crutches.....E0114
_____	<input type="checkbox"/> Arc 2.0 Shoulder Sling.....L3960

DVT Risk Assessment

Total All Columns and Check Risk that Applies	EACH RISK FACTOR = 1 POINT	EACH RISK FACTOR = 3 POINTS
<input type="checkbox"/> High Risk = 3 or more pts.	___ Age 40-59 years ___ History of prior major surgery (< 1 month) ___ Varicose veins ___ Swollen legs (current) ___ Obesity (BMI > 30) ___ Abnormal pulmonary function (COPD) ___ Medical patient currently at bed rest ___ Leg plaster cast or brace ___ Oral contraceptives or hormone replacement therapy ___ Pregnancy or postpartum (<1 month) ___ Use of tourniquet	___ Age 75 years or older ___ Major surgery lasting 2-3 hours ___ BMI>50 (venous stasis syndrome) ___ History of SVT, DVT/PE ___ Family history of DVT/PE ___ Present cancer or chemotherapy
	EACH RISK FACTOR = 2 POINTS ___ Age 60-74 ___ Major surgery (>60 Minutes) ___ Arthroscopic surgery (>60 minutes) ___ Laparoscopic surgery (>60 minutes) ___ Previous malignancy ___ Morbid obesity (BMI>40) ___ General anesthesia >30 minutes	EACH RISK FACTOR = 5 POINTS ___ Elective major lower extremity arthroplasty ___ Hip, pelvis or leg fracture (<1 month) ___ Multiple trauma (<1 month) ___ Major surgery lasting over 3 hours
<input type="checkbox"/> Moderate Risk = 2 pts.		Safety Considerations (check off if applicable) ___ Patient has severe peripheral arterial disease ___ Patient has congestive heart failure ___ Patient has an acute superficial DVT
___ High risk of bleeding	Other Risk Factors = 1 Point ___ Other: _____	
	___ Current smoker ___ History of hypercoagulability	

I have assessed that this patient is at risk of developing DVT. Because of this risk and limited ambulation, I am prescribing a DVT prevention therapy using a pneumatic compression device. In my opinion this is medically necessary and in accordance with standards of medical practice and appropriate treatment for this patient. I certify that the above prescribed medical equipment is medically indicated and in my opinion reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition. **Do not substitute.**

Physician's Original Signature: _____ Date: _____

Physician's Name: _____ Physician's NPI # _____

Clinic Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____