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SOLUTIONS
ORTHOCARE

EQUIPMENT SUPPLY STANDARD WRITTEN ORDER

PATIENT NAME: _____ **HIC#:** _____

ADDRESS: _____

PHONE: _____ **DOB:** _____

DATE OF ORDER: _____ **LENGTH OF NEED:** _____

DIAGNOSIS: (LIST ALL) _____

ITEMS ORDERED:

___ **L1845** **Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise**

PHYSICIAN NAME: _____ **PHYSICIAN NPI:** _____

ADDRESS: _____

PHONE: _____ **FAX:**_____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

I certify that I am the prescribing physician. I have reviewed this standard written order and confirm that the items prescribed and diagnosis are the best of my knowledge accurate.

PLEASE PROVIDE CHART NOTES FOR ABOVE ORDERED EQUIPMENT.