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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:

__ **L4386** Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

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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 the items prescribed and diagnosis are to the best of my knowledge accurate.

PLEASE PROVIDE CHART NOTES FOR ABOVE ORDERED EQUIPMENT.