PHYSICIAN'S PRESCRIPTION

F: 248.826.5120

Leaving a Legacy of Excellent Patient Care

Detroit Medical Devices

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Home Phone: _____ Cell Phone: _____

Right: _____ Left: _____

ICD-10 Code(s): _____

Procedure: _____

Date of Surgery (if applicable):

❑ Surgical ❑ Non-Surgical

Date of Injury (if applicable):

ORTHOPEDIC BRACING

- ❑ **AlignMed S3-SpinalQ**
- ❑ **AlignMed Posture Shirt or AlignMed Posture Bra**
- ❑ **Shoulder Sling**
- ❑ **Knee Brace**
- ❑ **Wrist Splint**
- ❑ **Other** _____

MISCELLANEOUS

- ❑ **SAM Sport**
- ❑ **TENS Unit**
- ❑ **Bone Growth Stimulator**
- ❑ **Other** _____

Size: _____ **OR Height:** _____ **Weight:** _____ **Chest:** _____ **Waist:** _____

Protocol: _____

COLD / COMPRESSION THERAPY UNITS & DVT

❑ **Recovery Plus** ❑ **VPULSE** ❑ **Other:** _____

❑ **SCD WITH DVT Unit** ❑ **DVT (PlasmaFlow)** ❑ 14 days ❑ 21 days ❑ 28 days

Protocol: _____

CONTINUOUS PASSIVE MOTION (CPM) UNITS

❑ **Knee CPM** ❑ **Hip CPM** ❑ **Shoulder CPM** ❑ **Wrist CPM** ❑ **Ankle CPM**

❑ Use to increase ROM, reduce joint stiffness ❑ 14 days ❑ 21 days ❑ 28 days

Protocol: _____

LENGTH OF NEED / MEDICAL NECESSITY

❑ Initial Rental Length of Need: _____

❑ Rental Extension Length of Need: _____

❑ Sale/Purchase Requested: _____

DO NO SUBSTITUTE (DAW): ❑

I, the undersigned, confirm the order for the above named patient. I certify that the prescribed treatment is medically reasonable and necessary in reference to accepted standards of medical practice within the community for treatment of this patient's condition.

Physician Name: _____ NPI: _____

Clinic Address: _____ Phone: _____

Physician Signature: _____ Date: _____

PLEASE FAX THIS FORM WITH A COPY OF PATIENT INSURANCE/DEMOGRAPHIC INFORMATION TO 248.826.5120