PRESCRIBER'S PRESCRIPTION

OrthoCor WC & PI

Rx

Patient				
	Patient Name:			
	ICD-10 Code:		**Do Not Substitute (DAW):** _____	
	Product:	**OrthoCor Medical - OrthoCor Active System and Pods** (Purchase Only)		
	Orientation:	☐ Left	☐ Right	☐ N/A

Contact Information		
	PLEASE FAX OR EMAIL COMPLETED FORM TO ORTHOCOR MEDICAL: **Fax: 888.314.8870 | Email: orders@orthocormedical.com**	
	For Billing Questions, Please Call: OrthoCor Billing: 573.214.2061 Ext. 1094	**For Inquires, Please Call:** OrthoCor Medical: 1.877.678.7354

Prescription Information		
	OrthoCuff: (Purchase Only)	
	☐ **Cervical - Universal Size**	☐ **Elbow - Universal Size**
	Foot / Ankle: ☐ **Medium** ☐ **Large**	**Hand / Wrist:** ☐ **Small** ☐ **Medium**
	Lumbar: ☐ **Small/Medium** ☐ **Large**	**Knee:** ☐ **Small/Medium** ☐ **Large**
	☐ **Hip - Universal Size**	☐ **Shoulder – Universal Size**
	Continuous Need:	**OrthoPods:** (Purchase Only)
		☐ 3 Months / 90 Pairs ☐ Other _____

Prescriber Information						
	Prescriber Signature:				**Date:**	
	Prescriber Printed Name:				**NPI:**	
	Address:					
	City:		State:		Zip:	