PeopleCare

Orthotics, Durable Medical Equipment, Surgical and Orthopedic supplies

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Detailed written order and statement of medical necessity

Physician information

Physicians Name:_____
NPI:_____
Telephone:_____Fax:_____
Addres:_____
City:_____ State:_____ Zip:_____

Patient information

Patient Name:_____
Sex:_____DOB:_____Telephone:_____
Insurance name:_____Insurance ID:_____
Addres:_____
City:_____ State:_____ Zip:_____

Please dispense the following items

Upper and mid extremity orthosis

- ☐ Back Brace / Lumbar-Sacral Orthosis
- ☐ Cervical Collar
- ☐ Shoulder splint
- ☐ Shoulder Wrist Elbow Hand Orthosis
- ☐ Elbow Orthosis, light weight
- ☐ Wrist Hand Finger Orthosis
- ☐ Brace for Hip osteoarthritis, Hip dysplasia, Pre & Post-op revisions

Lower extremity orthosis

- ☐ Knee Brace, hinged / Double upright, thigh & calf, knee orthosis
- ☐ Static or Dynamic Ankle Foot Orthosis (AFO)
- ☐ Knee Ankle Foot Orthosis (KAFO)
- ☐ Cam Walker / Walking boot for ankle stabilization (Pneumatic)
- ☐ Orthotic or Diabetic shoes
- ☐ Gradient Compression Stocking*: [Qty:___ pairs]
  __ *15-20 mmHg* __ *20-30 mmHg*
  30-40 mmHg *40-50 mmHg*

** Please include ankle and leg girth measurements.*

Pain and orthopedic devices

- ☐ Pain relief 'Ultrasound Diathermy' device and Supplies
- ☐ TENS Unit and Supplies
- ☐ TENS Device Garment
- ☐ Osteogenesis/Bone Stimulator: Spine Skull __ Other

Lymphedema & Deep Vein Thrombosis (DVT)

Pump Type:
- ☐ Non-segmental
- ☐ Segmental-Preset pressure
- ☐ Segmental-Variable pressure

Garment Set(s) Required: ☐ HEAD & NECK: ☐ TRUNK:
Upper extremity garment: ☐ LEFT ☐ RIGHT
Lower extremity garment: ☐ LEFT ☐ RIGHT

Urologicals

- ☐ **Intermittent Catheter: Qty:___**
  ☐ Straight tip ☐ Coude
  ☐ Hydrophilic
- ☐ Lubricant 3-gram packet
- ☐ Kit with insertion supplies
- ☐ Closed sterile system
- ☐ **French Size:**
  ☐ 8 Fr ☐ 10 Fr ☐ 14 Fr
  ☐ 16 Fr ☐ 20 Fr ☐ 22 Fr
- ☐ **Length:**
  ☐ 16' M ☐ 6' F ☐ 10' Pediatric
- ☐ **Foley Catheter:** (Medicare 1/month)
  __ Straight Tip __ Coude Tip
  __ 5cc __ 30cc 2 way
- ☐ **Condom Catheter:** (35/month)
- ☐ **Leg drainage bag & supplies qty:**
  __ 500 ml __ 1000 ml
- ☐ **Bedside drainage bag qty:**
  __ 2000 ml
- ☐ Other: _____

Wheelchairs

Wheelchair Type: ☐ Manual ☐ Reclining ☐ Power w/c or scooter
Wheelchair Size: *(Std. wheelchair - 18w X 16d with desk arms, ELR)*
Seat width*: 16' 18' 20' 22' 24' Other: __
Seat depth*: __ 16' 18' Other: __

Select arm rest and leg rest type

◉ Desk arms ○ Full arms • Elevating leg rest (ELR) Swing away footrest

Cushions & Accessories*:
- ☑ Include std. covered accessories*
- ☑ Standard Seat / Back cushion
- ☐ Adjustable skin Seat / Back cushion
- ☐ Roho cushion / Back

Additional Accessories:
- ☐ Arm trough
- ☐ Limb support
- ☐ Lap tray
- ☐ Other: _____

** Std. covered accessories include anti-tippers, brake extenders etc.*
Please strike through if accessories and cushions are not medically necessary.

Hospital beds and support surfaces

Bed Type*: ☐ Semi electric ☐ Full electric
Rails Type*: ☐ Half rails ☐ Full rails
Gel overlay*:__ (Y/N) Recommended if support surface is NOT a medical necessity
Trapeze Bar*: ☐ Free standing ☐ Bed attachment
Support Sufrace*: ☐ APP ☐ Low air-loss pressure mattress

Patient transfer systems

Patient Lift: ☐ Hydraulic/Manual ☐ Electric (Usually not covered)
Patient Transfer System: ☐ < 300 lbs ☐ 300 or more lbs



Start Date*:
ICD-10 Codes/ Diagnosis*:
_____ _____ _____ _____

Length of Need*: ___ months (99+ months for purchase / indefinite)
Additional information:

Physician Certification

This patient is being treated under a comprehensive plan of care. In my reasonable medical opinion, and in accordance with accepted standards of medical practice, I certify the medical necessity of these prescribed items for the above referenced patient.

Physician/APN Signature:_____ **Date:** _____