Performance Care

121 Fairway Dr. Nashville, TN 37214
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www.performance-care.com

MEDICAL BRACE PRESCRIPTION

Order Date: _____

Patient Name: _____ DOB: _____

Diagnosis: _____

Diagnosis Code(s): _____

I certify that the equipment selected below is medically necessary as part of the Care Plan for this Patient.

❑ LSO ❑ TLSO ❑ Spinomed Kyphosis Brace ❑ Scoliosis Bracing System

❑ Knee Brace, R / L ❑ Turbomed AFO, R / L ❑ Hand Splint, R / L ❑ Elbow Orthotic, R / L

❑ MultiPost Therapy Collar ❑ Other: _____

Bracing in order to (*Select all that apply*):

❑ Reduce pain by providing joint stability and/or restricting joint mobility (MUST BE NOTED IN CLINICALS)
❑ Support weak muscles and/or provide alignment for joint deformity (MUST BE NOTED IN CLINICALS)
❑ Facilitate healing following surgical procedure to the joint or related soft tissue (MUST BE NOTED IN CLINICALS)
❑ Facilitate healing following an injury to the joint or related soft tissue (MUST BE NOTED IN CLINICALS)

Additional Comments: _____

_____

Provider Signature: _____ Date: _____
Signature Required – No Stamps

Provider Name: _____ NPI: _____

Order Start Date: _____ Received Date: _____

FAX TO 615-953-7946

- Please include Patient Demographics & Clinical Note -