Performance Care
121 Fairway Dr. Nashville, TN 37214
Office Phone: 615-964-7632
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MEDICAL BRACE ORDER REQUEST

To: MD/NP/PA (Last)________________________________ (First)______________________ Phone: ________________________

Dear Provider,
Please review the following orthotic recommendation for your patient and contact us with any questions regarding this recommendation. Your signature and date are required. Thank you for allowing us to participate in your patient's care.

Nurse/Therapist Name: ____ Agency/Facility: ________________________________

Date: ________________________ Nurse/Therapist Phone Number: _____________________________________

Patient Name: ____ DOB: _________________________

Diagnosis: ____ * Diagnosis Code(s): ______________________________

Orthotic(s) Required:

❑ 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: ____

In order to (*Select all that apply*):

❑ Decrease pain by providing joint stability and/or restrict mobility
❑ Support weak muscles and/or provide alignment for joint deformity
❑ Facilitate healing following surgical procedure or injury to joint or related soft tissue
❑ Other: ____

Therapeutic Considerations (*Select all that apply*):

❑ With activities such as bending, lifting, and walking
❑ All the time as tolerated, except when resting or sleeping
❑ As needed according to pain levels
❑ Other: ____

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❑ Provide Orthotic as noted above ❑ OR:

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*** Signature verifies that the diagnosis code(s) above are accurate and documented in Patient's current medical record**

Dispense as written – Do not substitute

Provider Signature: ____NPI:_________________________ Date:___________

No stamps, original signature only please

PLEASE FAX TO 615-634-1116

Thank You!