Performance Care

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

MEDICAL BRACE ORDER REQUEST

To MD/DO/NP/PA: _____ Phone:_____ Fax: _____

Dear Provider,
Please review the following recommendation for your patient. I can be contacted at the number below if you have any questions. Performance Care is a local medical bracing provider and will fit this patient in their home. Thank you for allowing us to participate in your patient's care.

Nurse/Therapist: _____ Agency/Facility: _____ Phone: _____

Order Date: _____

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*):	**Therapeutic Considerations (*Select all that apply*):**
❑ Reduce pain by providing joint stability and/or restricting joint mobility ❑ Support weak muscles and/or provide alignment for joint deformity ❑ Facilitate healing following surgical procedure to the joint or related soft tissue ❑ Facilitate healing following an injury to the joint or related soft tissue ❑ Other: _____	❑ With activities such as bending, lifting, and walking ❑ All the time as tolerated, except when sleeping ❑ As needed according to pain levels ❑ While resting or sleeping ❑ Other: _____

❑ Provide Brace as Noted Above ❑ OR: _____

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

NPI: _____ Order Start Date: _____ Received Date: _____

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

FAX TO 615-953-7946

- Please Include Clinical Note -