Performance Care

MEDICAL BRACE PRESCRIPTION

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WWW.PERFORMANCE-CARE.COM

Patient Name: _____ DOB: _____ /_____ /_____

Diagnosis: _____ Diagnosis Code(s): _____

Orthotic(s) Required:

❑ LSO ❑ TLSO ❑ Spinomed ❑ Scoliosis Bracing System

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

❑ Aspen Vista 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: _____

Additional Comments: _____

_____

Dispense as written – Do not substitute

Prescriber Signature: _____ Date: _____ /_____ /_____

No stamps, original signature only please

Prescriber Name: (Last)_____ (First)_____

Prescriber NPI:_____ Phone: _____-_____-_____

FAX TO 615-634-1116

- Please Include Patient Demographics & Clinical Note -