Prescription & Certificate of Letter of Medical Necessity:

_____ Lower Extremity _____ Upper Extremity _____ Spinal / Orthotics

Patient: _____ **DOB:** _____

★Diagnosis: _____

The above named patient requires: _____

_____ Improve / maintain / Control alignment

_____ Protect a body segment from further injury

_____ Required for standing or transfer

_____ Improve functional stability

_____ Slow or prevent progression of deformity

_____ Outgrown / poorly fitting

_____. _____

The condition is: _____ Temporary _____ Permanent _____ Unknown

To be used: _____ During ambulation

_____ Night only

_____ 16-24 hours

_____ During recreational activities

_____ Under supervised care

Length of Need: _____ Permanent ___ Until condition improves/Changes

_____ _____

Prognosis: _____ Functional status of patient will be improved

_____ Deformity will be controlled / reduced

_____ Patient will be returned to activities of daily living

Doctor: _____

★Signature: _____

Address: _____ **Date:**

NPI: _____ **License #**