Atlantic HEALTHCARE PRODUCTS
www.AtlanticHP.com/Rx

Prescription: Bracing

PATIENT INFORMATION

Patient:_____

DOB:_____

Order Date:_____

Patient Contact Number: _____

Patient Height: _____

Patient Weight: _____

DIAGNOSIS

❑ DX Code:_____ ❑ Length of need: 99 or _____

STEP 3 | BRACING PRESCRIPTION

Cervical
- ❑ Cervical Collar - Soft
- ❑ Cervical Collar - Rigid

Foot/Ankle
- ❑ AFO For Foot Drop
- ❑ Ankle Brace - Stirrup Style
- ❑ Ankle Brace - Lace Up Style
- ❑ Walking Boot - Tall
- ❑ Walking Boot - Short
- ❑ Heel Suspension Boot/Pressure Reduction
- ❑ Night/Recumbent Positioning Splint
- ❑ Offloading Shoe
- ❑ Post OP Shoe

Knee
- ❑ Hinged Knee Brace
- ❑ Hinged Knee Brace with Condyle Pads
- ❑ ACL Brace - Custom
- ❑ ACL Brace - Off-the-shelf
- ❑ OA Brace - Custom
- ❑ OA Brace - Off-the-shelf
- ❑ Knee Immobilizer
- ❑ Post OP Knee Brace
  Flex°_____ Ext°_____

Spinal
- ❑ LSO With Stays
- ❑ LSO With Rigid Posterior
- ❑ LSO With Rigid Anterior and Posterior
- ❑ TLSO With Rigid Anterior and Posterior

Wrist
- ❑ Wrist Splint
- ❑ Wrist Forearm Splint
- ❑ Wrist/Thumb Spica Splint

Shoulder
- ❑ Shoulder Immobilizer

LENGTH OF NEED

Please note: this informa ion is required.

Length of need _____ Number of Months

(1 to 99 months | 99 months = lifetime)

PATIENT QUESTIONS

1. Has this patient had this equipment before? ❑ yes ❑ no If yes, when? _____
2. Is this patient room/bed bound? ❑ yes ❑ no
3. Is the patient's bathroom located on a floor they can access? ❑ yes ❑ no
4. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one of more Mobility Related Activities of Daily Living (MRSDLs) - such as toileting
5. feeding, dressing, grooming and bathing in the home? ❑ yes ❑ no If yes, please explain: _____
   _____
6. Are there any other conditions that limit the patient's ability to participate in MRADLs at home? ❑ yes ❑ no
   If yes, please list applicable conditions:
   _____

Note: *This form serves as a WOPD. Fax this form and patient demographic sheet which includes insurance information to 561-290-1434.*

PHYSICIAN INFORMATION

Practitioner's Name:_____

NPI:_____

Practitioner's Signature **Date**