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**Please fax completed form to 612-223-8661
STANDARD WRITTEN ORDER (SWO)**

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Insurance: _____ ID #: _____

| | |
|---|---|
| <p>Spine</p>  <p><input type="checkbox"/> L0650 Lumbar Support w/Lateral Stability</p>  <p><input type="checkbox"/> L0648 Lumbar Support</p>  <p><input type="checkbox"/> L0642 Lumbar Support Low Profile</p>  <p><input type="checkbox"/> L0457 Thoracic Support</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Lumbago / Low Back Pain (M54.5) <input type="checkbox"/> Arthrosis - Lumbar/Thoracic (M47.817 / M47.814) <input type="checkbox"/> Degenerative Disc Disease (M51.36) <input type="checkbox"/> Disc Replacement (M50.2 / M51.26 / M51.84) <input type="checkbox"/> Fracture (S12.9XXA / S32.0008A / S22.009A) <input type="checkbox"/> Kyphosis/Scoliosis (M40.00 / M48.04) <input type="checkbox"/> Radiculitis (M54.16) <input type="checkbox"/> Stenosis - lumbar/thoracic (S33.5XXA / S23.3XXA) <input type="checkbox"/> Other: _____ |
| <p>Lower Extremity <input type="checkbox"/> Left <input type="checkbox"/> Right</p>  <p><input type="checkbox"/> L1902 Ankle Brace</p>  <p>Walking Boot Pneumatic <input type="checkbox"/> L4361 Non-Pneumatic <input type="checkbox"/> L4387</p>  <p>Night Splint Posterior <input type="checkbox"/> L4397 Dorsal <input type="checkbox"/> L4397</p>  <p><input type="checkbox"/> L1951 OTS AFO</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Achilles Bursitis (M76.62 / M76.61) <input type="checkbox"/> Foot Drop (M21.372 / M21.371) <input type="checkbox"/> Fracture (S84.375A / S84.374A) <input type="checkbox"/> Instability (M24.872 / M24.871) <input type="checkbox"/> Plantar Fibromatosis (M72.2) <input type="checkbox"/> Sprain (S93.401A / S93.402A) <input type="checkbox"/> Other: _____ |
| <p>Upper Extremity <input type="checkbox"/> Left <input type="checkbox"/> Right</p>  <p><input type="checkbox"/> L3908 Wrist Splint</p>  <p><input type="checkbox"/> L3809 Wrist & Thumb Splint</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Carpal Tunnel Syndrome (G56.00) <input type="checkbox"/> Rheumatoid Arthritis and other inflammatory polyarthropathies (M06.9) <input type="checkbox"/> Sprains and Strains of radial carpal (joint)(ligament) (S63.329A/S66.529A) <input type="checkbox"/> Sprains and Strains of the wrist (S63.90XA/S66.919A) <input type="checkbox"/> Radial Styloid Tenosynovitis (M65.4) <input type="checkbox"/> Other: _____ |
| <p>Knee <input type="checkbox"/> Left <input type="checkbox"/> Right</p>  <p><input type="checkbox"/> L1833 Hinged Knee Brace</p>  <p><input type="checkbox"/> L1851 OA Knee Brace</p> | <ul style="list-style-type: none"> <input type="checkbox"/> ACL Disruption (M23.612 / M23.611) <input type="checkbox"/> Cartilage Tear (S83.502A / S83.501A) <input type="checkbox"/> Dislocation (S83.105A / S83.104A) <input type="checkbox"/> Instability (M23.52 / M23.51) <input type="checkbox"/> Osteoarthritis (M17.12 / M17.11) <input type="checkbox"/> Sprain (S83.8X2A / S83.8X1A) <input type="checkbox"/> Other: _____ |
| <p><input type="checkbox"/> Other: _____</p> | <p>Diagnosis: _____</p> |

I certify that the above prescribed equipment is medically indicated and supports standards of medical practice for this diagnosis.

Ordering Doctor: _____ NPI: _____ Phone: _____

Signature: _____ Date: _____ Fax: _____