BAUERFEIND®

Medical Device Recommendation

Referrer Details

Clinician:

Provider no.

(Medicare provider no if applicable):

Signature:

Date: ____/____/_____

Patient Name:

Pathology/Diagnosis:

Clinical Reason for product:

Recommended Product/Products:

- Medical Compression Garments
  - ☐ VenoTrain ☐ Knee ☐ Thigh ☐ Waist
- Knee Supports
  - ☐ GenuTrain ☐ GenuTrain A3 ☐ GenuTrain P3 ☐ GenuTrain S/Pro
- Hinged Knee Braces
  - ☐ SecuTec Genu ☐ SecuTec OA ☐ GenuTrain OA ☐ GenuLoc
- Foot Supports & Braces
  - ☐ MalleoLoc ☐ AchilloTrain ☐ MalleoTrain ☐ S/Plus/Open
- Back Supports
  - ☐ SacroLoc ☐ LumboLoc ☐ LumboTrain ☐ Other
- Wrist/Thumb Supports & Braces
  - ☐ ManuTrain ☐ RhizoLoc ☐ ManuLoc ☐ Other
- Elbow/Shoulder Support
  - ☐ EpiTrain ☐ EpiPoint ☐ OmoTrain/S ☐ Other

Other – Please provide details: