MEMORIAL THERAPEUTIC PRODUCTS, INC.
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PRESCRIPTION FORM/CERTIFICATE OF MEDICAL NECESSITY

Patient Name:	Patient SS#:
Physician:	DOI:

Surgical Fit Instructions: Surgical Date: __________ Time: __________ AM/PM Location: ________________

Nonsurgical Fit Location: ❑ Home ❑ Physician's Office ❑ Physical Therapy ❑ Other ____________

Diagnosis/ICD9:

Electromedical Devices & Bone Growth Stimulator Products:

❑ Interferential Device, plus supplies
❑ EMS Device, plus supplies
❑ TENS Device, plus supplies
❑ Conductive Garment
Length of Use: __ 1-3 Month __ 1 Month __ Purchase & supplies prn

Indications Relating to Medical Necessity:

❑ Manage Chronic Pain
❑ Relax Muscle Spasms
❑ Reduce Swelling
❑ Increase/Maintain ROM
❑ Decrease Medications
❑ Manage Acute or Post-op Pain
❑ Prevent/Retard Disuse Atrophy
❑ Increase Circulation
❑ Muscle Re-education

❑ Bone Growth Simulator

❑ Non-union Fracture
❑ Failed Fusion
❑ Other: __________________
Risk Factors: ❑ Smoker ❑ Obese ❑ Diabetic ❑ Alcoholic

Moist Heat Products & Analgelsics:

❑ Biofreeze ❑ Sombra ❑ Paraffin Bath
❑ Moist Heat: ___ Small ___ Large ___ Other________________________

Indications Relating to Medical Necessity:

❑ Manage Chronic Pain ❑ Manage Acute or Post-op Pain
❑ Relax Muscle Spasms ❑ Reduce Swelling ❑ Reduce Inflamation

Ambulatory Aids

❑ Wheel Chair ❑ Walker ❑ Walker with Seat and Brakes
❑ Cane ❑ Crutches ❑ Cane _____Single _____ Quad
❑ 3-n-1 Commode ❑ Toilet Seat Riser ❑ Other________________________

Indications Relating to Medical Necessity:

❑ Increase ROM
❑ Increase Circulation
❑ Increase Functional Ability
❑ Increase Mobility
❑ Reduce Joint Inflamation
❑ Reduce Pain

Lower Extremity and Upper Extremity Bracing Products

❑ **Right** ❑ **Left** ❑ **Medial** ❑ **Lateral**

❑ Custom Osteoarthritis Knee Brace & Liners as needed
❑ Custom Unloader Knee Brace & Liners as needed
❑ Prefabricated (OTS) Ligament Knee Brace & Liners as needed
❑ Post Op Knee Brace/Immobilizer ❑ Patella Femoral Brace
❑ Walker Boot/Camwalker: ___ Short ___ Medium ___Tall
___ Pneumatic ____ Air Walker with Pump
❑ Ankle Stirrup ❑ Lace-up/Exoskeleton/Figure 8 ❑ Compression Ankle Brace
❑ Night Splint ❑ _____ AFO _____Fixed ____ Articulating
❑ Functional Arm Brace ❑ Shoulder Immobilizer
❑ Carpal Tunnel Brace ❑ Carpal Tunnel Brace w/ Thumb Immobilizer
❑ Thumb Spica ❑ Arm Sling
❑ Epicondylitis Brace/Tennis Elbow ❑ Compression Sleeve
❑ Other ____

Spine and Cervical Bracing/Therapy Products

❑ LSO Brace ____ Post Op/Rigid ____Semi-Rigid ___ w/Chair Back
❑ TLSO _____Sternal Pad ___ Dorsal Lumbar Extension
❑ Cervical Collar ___ Semi-Rigid ___Soft ❑ Clavicular Brace
❑ Mattress Overlay ❑ Cervical Pillow (Purchase Only)
❑ Therapeutical Pillow (Purchase Only) ❑ Leg Spacer Pillow ❑ Lumbar Cushion
❑ Whirlpool Spa ❑ Knee Elevator ❑ Other ______ ________
❑ TRACTION ____ Lumbar (Saunders)
____ Cervical: ❑ Posture Pump ❑ NeckPro (OTD) ❑ Saunders

Indications Relating to Medical Necessity:

❑ Manage Osteoarthritic Pain/Symptoms
❑ Correct Varus/Valgus Deformity
❑ Correct Abnormal Limb Contour/Deformity
❑ Protect/Stabilize Joint
❑ Limit ROM
❑ Increase ROM
❑ Protect Ligament Injury
❑ Correct Patella-Femoral Malalignment
❑ Protect Surgical Repair
❑ Improve Coordination/Proprioception
❑ Manage Plantar Fascitis Pain
❑ Correct Drop Foot
❑ Reduce Joint Stiffness
❑ Other ____
____
____

Orthotics and Diabetic Products

❑ Non-Diabetic ____Functional _____Accommodative
❑ Diabetic (Trilaminate ONLY) ______w/Diabetic Shoes
❑ Compression Hose: ____________Knee______ Thigh _____ Full

Indications Relating to Medical Necessity:

❑ Lumbar Instability
❑ Pes Planus
❑ Bone Spur Relief
❑ Leg Length Discrepancy
❑ Pes Cavus
❑ Ankle Instability

Miscellaneous Products:

❑ C-Pap: __________________________ Mask __________________________
❑ Exercise Kit: ___Lumbar ___Ankle/Foot ___Cervical ___Elbow/Hand/Wrist ___Shoulder
❑ Pedal Exerciser

Indications Relating to Medical Necessity:

❑ Relax Muscle Spasms
❑ Reduce Joint Stiffness
❑ Improve ADLs/Functioning
❑ Increase ROM
❑ Muscle Re-education
❑ Manage Acute or Post-op Pain

*Other Comments:*____

I, the undersigned, confirm the order for the above-named patient. I also certify that the prescribed treatment is medically reasonable and necessary in reference to accepted standards of medical practice within the community for treatment of this patient's condition.

Physician's Signature: ______________________________ Date: ______________________________