Please call for appointment

Ortho Plus, Inc.

Orthopedic Products & Services

PRESCRIPTION

Date: _____

Patient: _____ Date of Birth: _____

Diagnosis: _____

Extremety: RT _____ LT _____

Length of Need: _____

Prognosis: Poor _____ Fair _____ Good _____

____ C.P.M. (E0935) Settings _____

____ Cold Therapy (E0218) _____ Plexi Pulse/Talley (E0675)

____ T.E.N.S. Unit (E0730) _____ Muscle Stimulator (E0745)

____ Bone Growth Stimulator (E0747)

____ Bracing (off the shelf) Specifics: _____

____ Other (please specify): _____

_____

LETTER OF MEDICAL NECESSITY:

The above patient has been under my care and will be in need of the prescribed modality. This was prescribed to aid in/or accelerate the rehabilitation process and is deemed medically necessary.

Physician Name (please print): _____

Physician Signature: _____

NPI Number: _____

Comments of Notes:

Toll Free (800) 940-0195 Phone (210) 541-8568 Fax (210) 541-8571
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San Antonio Austin Dallas/Fort Worth McAllen Corpus Christi Laredo Del Rio