DETAILED WRITTEN ORDER/PRESCRIPTION

PATIENT NAME: ____

DIAGNOSIS: ____

ITEM(S) PRESCRIBED: Dynamic articulated ankle foot orthosis with molded inner boot, dorsiflexion assist ankle joints, and inversion/eversion control.

MEDICAL NECESSITY: ____

____

____

REFERRING PHYSICIAN: ____

PHYSICIAN'S SIGNATURE: ____________________________ DATE: __________

ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE: __________

PHONE: (______) ______________________ FAX: (______) ______________________

LICENSE #: ________________ UPIN #: ________________