**ANKLE ORTHOSIS**

**Date\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **DOB**: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |
| **Insurance/ID#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Tel.:** (\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| **Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **State/Zip**\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Treating Physician**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **NPI# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City** \_\_\_\_\_\_\_ | **State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Tel** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

To facilitate healing following an injury

Tofacilitate healing following a surgical procedure

I certify that the following statement is true: (check all that apply)

|  |  |
| --- | --- |
| Plantar FascialFibromatosis (728.71)Bursitis of Foot (726.79)  PesAnserinus Bursitis (726.61)Achilles Bursitis/Tendinitis (726.71)Enthesopathy of Ankle/Tarsus (726.70) | Pain in Ankle/Foot Joint (719.47)Ankle Sprain/Strain (845.00)Calcaneal Spur (726.73)Osteoarthrosis of Ankle/Tarsus (715.97) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Duration: Patient has had this condition for \_\_\_ month’s \_\_\_ years. (Chronic = 3 months or more)

Estimated Length of Ankle Orthosis Need (# of Months)\_\_\_\_ 1-99 (99 = Lifetime)

**Other**

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Our evaluation of the above patient has determined that providing the ankle orthosis product will benefit this patient.

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***Physician Signature M.D. or D.O. Date***