**LUMBAR ORTHOSIS**

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

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

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

*It is in my expert opinion that an LSO/TLSO is medically necessary to facilitate management*

*of this patient’s diagnosis. Please, dispense as written.*

To facilitate healing following a surgical procedure on the spine or related soft tissue:

 Date of procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To facilitate healing following an injury to the spine or related soft tissue.

To reduce pain by restricting mobility of the trunk.

To otherwise support weak spinal muscles and/or a deformed spine.

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

|  |  |
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| Lumbago (724.2) Lumbosacral Sponsylosis (721.3) Spinal Stenosis (724.0)Lumbar Strains / Sprain (847.2)Muscle Weakness (728.87) Scoliosis (737.30)  Closed fracture of lumbar vertebra (805.4)  | Spinal Disorder (724.9) Spondylolisthesis (756.12)Thoracic or lumbosacral radiculitis (724.4)Lumbar Disc Displacement (722.10) Disc Degeneration (722.52) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

Estimated Length of Back Brace Need (# of Months)\_\_\_\_ 1-99 (99 = Lifetime)

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Our evaluation of the above patient has determined that providing the back pain management LSO/TLSO product will benefit this patient.

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