TOLL FREE PHONE 1-888-897-3231
TOLL FREE FAX 1-888-997-3231
EMAIL: APRIL@ALLTECHOP.COM
IN- FACILITY & IN-HOME VISITS AVAILABLE
SEE BACK FOR OFFICE LOCATION AND MAP

## *PRESCRIPTION / MEDICAL NECESSITY & ORDER FOR CONSULT / TREATMENT*

***PLEASE ATTACH A COPY OF PATIENT'S FACESHEET OR DEMOGRAPHICS***

Patient Name: ______________________________________________ Date: ________________________

Diagnosis: ______________________________________________ ICD-10 Code (s): _________________

Prognosis: ____________________________________ Length of Need: _______________ #of mos. 99= life)

**PLEASE INDICATE NEED BELOW BY CIRCLING:**

| UPPER EXTREMITY PROSTHETICS: | AFFECTED SIDE: | | |
|---|---|---|---|
| ABOVE ELBOW (AE) | LEFT | RIGHT | BILATERAL |
| BELOW ELBOW (BE) | LEFT | RIGHT | BILATERAL |
| PARTIAL HAND | LEFT | RIGHT | BILATERAL |

**OTHER:** ______________________________________________________________________________

| LOWER EXTREMITY PROSTETICS: | AFFECTED SIDE: | | |
|---|---|---|---|
| ABOVE KNEE (AK) | LEFT | RIGHT | BILATERAL |
| BELOW KNEE (BK) | LEFT | RIGHT | BILATERAL |
| PARTIAL FOOT | LEFT | RIGHT | BILATERAL |

**OTHER:** ______________________________________________________________________________

***MOST PROSTHETIC PATIENTS BENEFIT FROM PHYSICAL MEDICINE & REHABILITATION ASSESSMENT. IF YOU WOULD LIKE YOUR PATIENT REFERRED TO A PM&R PHYSICIAN FOR EVALUATION & CASE MANAGEMENT OF THEIR PROSTHETIC CARE, PLEASE INITIAL*** _________

*Physician's Name:* ____________________________________ *NPI:* ______________________________

*Physician's Address:* __________________________________ *City, State, Zip:* ______________________

*Phone #:* ____________________________________________ *Fax:* ______________________________

*Physician's Signature:* _________________________________ *Date:* _____________________________