Gazelle Healthcare Solutions
"Increase the Intensity"

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REP: ______________

New Order Form

Patient Name: ____ Date: ___________________________

Procedure: ____ DX Code: _________________________________

Date of Surgery: _______________ Surgery Location: ________________________ Discharge Date: ___________
Duration: _______ 14 Days _______ 21 Days _______ 28 Days _______ 99 months

Certificate of Medical Necessity: The modalities below are required during the normal course of patient rehabilitation in order to protect the injury, rehabilitation or surgical repair. These modalities will allow the patient to resume normal activities of daily living more quickly and at less cost. These modalities are an essential part of our post-operative, post-injury treatment, rehabilitation and are prescribed to preserve the integrity of the surgical procedure and/or prevent further damage to the site or to aid in patient returning to activities of daily living.

_____ **BONE STIM** ____________________ **BODY PART**
NEEDS 90 DAY XRAYS EXCEPT FOR MULTI LEVEL FUSIONS

_____ **FRACTURE BOOT** (TALL SHORT)
RIGHT LEFT (S82.843, S82.63X, S93.409)

_____ **ROM KNEE BRACE** **(**RANGE ______ TO ______**)**
RIGHT LEFT (S83.219A/D, S83.419A/D, S83509A/D)

_____ **ROM ELBOW** **(**RANGE ______ TO ______**)**
RIGHT LEFT (S52.023A/D, S52.123A/D, M66.829)

_____ **SHOULDER ABDUCTION PILLOW**
RIGHT LEFT (M75.00, M75.50, M75.30, M75.40)

_____ **WRIST BRACE**
RIGHT LEFT (G56.00, M19.039, S52.509A/D)

_____ **THUMB SPICA**
RIGHT LEFT (M65.4, M24.239)

_____ **HINGED KNEE BRACE**
RIGHT LEFT (M17.10, S83.429, S83.509, S83.419, S83.90X)

_____ **PATELLA STABILIZER**
RIGHT LEFT (M22.2X1, M22.2X2, S83.90XA/D)

_____ **ANKLE BRACE** (LACE UP STIRRUP)
RIGHT LEFT (S93.409. S82.843. S82.63X)

_____ **ACL BRACE** RIGHT LEFT (S83.509A/D)
Measurements: Thigh ______ Knee ______ Calf _______

_____ **OA BRACE** RIGHT LEFT (M17.10)
Measurements: Thigh ______ Knee ______ Calf _______

_____ **LSO BACK BRACE (SHORT) (**M54.5, M54.16, G54.9)

_____ **LSO BACK BRACE** (M51.36, M54.16, M51.26, M54.5)

_____ **LSO BACK BRACE (W/SAGITAL PANELS)**
(M51.36, M54.16, M51.26, M54.5)

_____ **TLSO** (M51.34, 51.04, 51.24)

_____ **UNLOADER HIP** (S33.6XXA**,** M16.9, M16.11)

_____ **TENS UNIT**

_____ **MUSCLE STIMULATOR**

_____ **CPM** KNEE SHOULDER ANKLE WRIST

_____ **DVT UNIT**

_____ **CRYO/HEAT THERAPY**
RIGHT LEFT KNEE SHOULDER ANKLE ELBOW WRIST

OTHER:

NOTES:

Physician Name: ____ Phone #: ____________________

Physician Signature: ____ NPI Number: __________________