Gazelle Healthcare Solutions
"Increase the Intensity"

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Phone Number: 855-827-9990
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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: _____