LETTER OF MEDICAL NECESSITY

Patient Name:_____

DOB:_____/_____/_____ **SS#:**_____-_____-_____

___ Wrist Brace
___ Cervical Traction Collar
___ Custom Foot Orthotics
___ Custom (TLSO) Orthosis Lumbar Brace
___ TENS/EMS Unit + ___# pads (for purchase)
___ Garment Electrode (Glove, Sock, Elbow, Knee)

Diagnosis:_____ **ICD.9 Code:**_____
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___inhibit intractable pain
___break muscle spasm
___stimulate muscle contraction
___increase range of motion
___increase blood flow
___re-educate muscles
___reduce pain by restricting mobility of the trunk
___other_____
____reduce edema from trauma/post-op procedure
____decompress spinal nerves
____restore lordotic curve
____balance short leg
____correction of foot pronation
____stabilize the spine

___TENS/EMS unit for home use for the purpose of decreasing pain/ decreasing spasm as well as reducing the patient's treatment schedule and initiating a release from active care for an at home exercise program. Patient was instructed to operate a TENS/EMS unit, utilizing settings as follows:

___TENS Prognosis: _____
Pulse width _____us Pulse mode_____-Hz
Mode:_____ Timer:_____ Durations:_____mins.
Other:_____
_____

_____Long-term use (for purchase)
Date unit was issued:_____-
Rental _____---Month(s)
(specify no. of months)

_____ _____/_____/_____
Patient's Signature **Date**

_____
Doctor's Name (Please Print)

_____ _____/_____/_____
Doctor's Signature **Date**