

DOD ID #

	PATIENT INFO	DOB/dd /yyyy	
Last N	Name	First Name	
Phone E-mail Benefits Number			
Sex Diagnosis Code(s) Length of Need (1-99)			
Address listed above same as shipping? YES NO Do you have OHI (Other Health Insurance)? YES NO			
OR	IENTATION: RIGHT LEFT Universal	Large X-Large XX-Large Universal Custom Bilateral Medial Lateral flex OtherQUANTITY	
TEN SER	TENS Combo and Year Supply Kit TENS (for purchase/lifetime use)	Sole Support UCB Custom OrthoticL-3000-2 1 pair: Other (Choose ONE) Dress Field Garrison Night Splint L4397 AFO L1951* L1932* Walking Boot L4361 Ankle Brace L1906 L1902	
LSO TLSO Cei	rment Type Multi-Purpose Cervical Shoulder Knee/Arm Hand/Wrist Foot/Ank Year Supply of Electrodes		
Hip	Brace L1686*	HCPCS Code(include sizing/orientation)	
ARM M	DM Elbow L3761 TO Brace L3809 Trist Brace L3908 Inged Wrist Brace L3916	*Place Product Sticker here or write in specfic product type here in this box.*INCLUDE SERIAL #'s	
	oulder Brace	Pro	
*All products with red asterisk require a custom fit form and applicable customizations			
☐ Electronic Physician Signature on Referral			
Physician Signature			
l ackr busin Tactic	nowledge I have been fit/cast for the product indicated ess days to pick up. If after a minimum of 10 days of paral Rehabilitation has permission to ship my product to	above, and my product will be available within 7-10 product availability, the facility is not able to make contact with me, the shipping address provided.	
Patient Signature Today's Date/			
I have	e received the product(s) listed above and have been tra	ained/instructed on its proper use.	
Patient Signature/Tracking Date/			

Verbal Verification via (for shipped items only): Text Email Call Date of Verification