PRESCRIPTION FORM

Patient Information:

Patient _____
Home address _____
City, State, ZIP _____
_____

Date of birth _____
Phone number _____
SSN _____
Gender _____ Male _____ Female

Insurance Information:

____No Fault
____Worker's Compensation

Insurance name: _____
Address _____
_____
Contact _____
Phone _____
Fax _____

Date of injury _____
WCB number _____
Case number _____
Employer _____
Date of surgery _____

Current condition: _____
Previous treatment: _____
Reason medically - necessary: _____
_____

Product Prescribed:

____Motion X and 12 months supplies
____IF Unit and 12 months supplies
____Fusion TLSO
____Fusion

Measurements:

_____Waist (Inches)
_____ Hips (Inches)
_____ Height (Feet)
_____ Weight

Lordotic Curve:

____In degrees
____Hyper
____Normal
____Hypo

Diagnosis codes:

___M51.26 Other intervertebral disc displacement, lumbar region
___M51.27 Other intervertebral disc displacement, lumbosacral region
___M51.36 Other intervertebral disc degeneration, lumbar region
___M51.37 Other intervertebral disc degeneration, lumbosacral region
___M43.27 Fusion of spine, lumbosacral region
___M43.28 Fusion of spine, sacral and sacrococcygeal region
___M53.2X7 Spinal instabilities, lumbosacral region
___M53.3 Sacrococcygeal disorders, not elsewhere classified
___M51.06 Intervertebral disc disorders with myelopathy, lumbar region
___M51.07 Intervertebral disc disorders with myelopathy, lumbosacral region
___Q76.2 Congenital spondylolisthesis
___M47.817 Spondylosis without myelopathy or radiculopathy, lumbosacral region
___Other_____
___Other_____
___Other_____
___Other_____
___Other_____
___Other_____

___M99.01 Segmental and somatic dysfunction of cervical region
___M99.02 Segmental and somatic dysfunction of thoracic region
___M99.03 Segmental and somatic dysfunction of lumbar region
___M99.04 Segmental and somatic dysfunction of sacral region
___M99.05 Segmental and somatic dysfunction of pelvic region
___M54.14 Radiculopathy, thoracic region
___M54.15 Radiculopathy, thoracolumbar region
___M54.16 Radiculopathy, lumbar region
___M54.17 Radiculopathy, lumbosacral region
___M54.32 Sciatica, left side
___M54.31 Sciatica, right side
___M48.06 Spinal stenosis, lumbar region
___Other_____
___Other_____
___Other_____
___Other_____
___Other_____
___Other_____

[X] DISPENSE AS WRITTEN

I certify that the above prescribed products, supplies, and accessories provided soley by W.J.W. Medical Products, are medically necessary as part of my treatment plan for this patient's condition as stated above. According to Code of Federal Regulations this prescription is intended for exclusive use by W.J.W. Medical Products Inc., and is considered invalid if used otherwise.

Doctor's Signature: _____ Date: _____
Doctor's Name: _____
Address: _____
Doctor's Phone: _____ Doctor's Fax: _____
Doctor's Email: _____

FAX 1-888-400-9151