

# Prescription for Orthotics

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Diagnosis Code: (ICD10) \_\_\_\_\_

• **PLEASE CHECK SELECTION**

Wrist Brace \_\_\_\_\_

TLSO Back Brace \_\_\_\_\_

LSO Back Brace \_\_\_\_\_

OA Knee Brace \_\_\_\_\_

Knee Ligament Brace \_\_\_\_\_

Walking Boot/CAM Walker \_\_\_\_\_

Ankle Foot Orthosis (AFO) \_\_\_\_\_

Custom Inserts \_\_\_\_\_

LEFT

Night Splint \_\_\_\_\_

Other \_\_\_\_\_

Bilateral

RIGHT

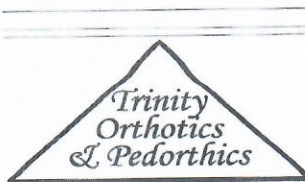
Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician (Printed Name) \_\_\_\_\_

Address: \_\_\_\_\_

NPI: \_\_\_\_\_

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