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 _____ ○ Bilateral

☐ Ankle Foot Orthosis (AFO) _____ ○ RIGHT

☐ Custom Inserts _____ ○
LEFT

☐ Night Splint _____

☐ Other _____

hysician Signature: _____ Date: _____

Physician (Printed Name) _____

Address: _____

NPI: _____

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