HILL COUNTRY Orthotics & Prosthetics

Orthotic & Prosthetic Order Form

PHONE: (210) 614-8777 • FAX: (210) 694-4581

DEMOGRAPHICS SHEET SENT SEPARATELY? ☐ YES ☐ NO

- **Patient Information**

Name | DOB | Phone Number 1 | Phone Number 2

Address Line 1 | City | State | ZIP | Sex

Primary Insurance Provider | Member ID # | Relationship to Subscriber

Secondary Insurance Provider | Member ID # | Relationship to Subscriber

- **Referring Provider Information**

Name | Credentials | Phone Number | Fax Number

NPI | Address Line 1 | City | State | ZIP

- **Primary Care Physician Information**

Name | Credentials | Phone Number | Fax Number

NPI | Address Line 1 | City | State | ZIP

1) Prescription

ICD-10(s) | Description(s)

PROSTHETIC ITEMS NEEDED:

Side: ☐ Left ☐ Right ☐ Bilateral

Level:

☐ Above Knee ☐ Above Elbow
☐ Below Knee ☐ Below Elbow
☐ Partial Foot ☐ Partial Hand
☐ Hip Disarticulation ☐ Shoulder Disarticulation
☐ Knee Disarticulation ☐ Elbow Disarticulation
☐ Symes ☐ Wrist Disarticulation

Please evaluate and treat for:

☐ New Prosthesis ☐ Replacement Prosthesis
☐ Replacement Socket ☐ Preparatory Prosthesis
☐ Supplies: _____
☐ Other (specify): _____

ADDITIONAL PROSTHETIC ITEMS NEEDED:

Side: ☐ Left ☐ Right ☐ Bilateral

Level:

☐ Above Knee ☐ Above Elbow
☐ Below Knee ☐ Below Elbow
☐ Partial Foot ☐ Partial Hand
☐ Hip Disarticulation ☐ Shoulder Disarticulation
☐ Knee Disarticulation ☐ Elbow Disarticulation
☐ Symes ☐ Wrist Disarticulation

Please evaluate and treat for:

☐ New Prosthesis ☐ Replacement Prosthesis
☐ Replacement Socket ☐ Preparatory Prosthesis
☐ Supplies: _____

ORTHOTIC ITEMS NEEDED:

Side: ☐ Left ☐ Right ☐ Bilateral ☐ N/A

Custom or Off the Shelf: ☐ Custom ☐ OTS

Lower Extremity

☐ AFO (Ankle Foot) ☐ KAFO (Knee Ankle Foot)
☐ Arizona Style AFO ☐ HKAFO (Hip Knee Ankle Foot)
☐ CROW Boot (Charcot) ☐ KO - Hinged (Knee)
☐ Walking Boot (CAM) ☐ KO - Knee Immobilizer
☐ Other (specify): _____

Upper Extremity

☐ WHO (Wrist Hand)
☐ WHFO (Wrist Hand Finger)
☐ Elbow
☐ Shoulder

Spinal

☐ LSO (Lumbar Sacral)
☐ TLSO (Thoracic, L, S)
☐ Scoliosis (send XRays)
☐ Cervical

LENGTH OF NEED: _____

The above procedures/devices are appropriate for this patient and are deemed medically necessary.

Signature | Name | Credentials | NPI | Date

2) ☐ **Progress Notes** with justification for the device and K-Level (when applicable) included with order.

Guidelines for determining K-Level can be found here: HillCountryOandP.com/KLevel

FIND US ON LEADING REACH!