# DWO for Dynamic Splints

*FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622*

**DATE OF ORDER:**_____

**DATE OF LAST FACE TO FACE:**_____

## PATIENT INFORMATION

**First Name**_____ **Last Name**_____

**Address**_____ **City**_____ **State**_____ **Zip**_____ **Phone**_____

**Date of Birth**_____ **Emergency Contact**_____ **Emergency Contact Phone**_____

## REFERRING PT OR CLINIC INFORMATION (if applicable)

**Clinic Name**_____ **Therapist Name** _____

**Clinic Address**_____ **City**_____ **State**_____ **Zip**_____

**Phone**_____ **Fax**_____ **Therapist Email**_____

## PRODUCT PRESCRIBED

| | Check Item: | MUST CIRCLE ONE: | Billable HCPCS: | MUST CIRCLE ONE: |
|---|---|---|---|---|
| ☐ | JAS EZ Elbow | Right or Left or Both | L3740 | Flexion or Extension or Both |
| ☐ | Dynamic Elbow | Right or Left or Both | E1800 | Flexion or Extension or Both |
| ☐ | JAS EZ Pro/Sup | Right or Left or Both | L3766 | Pronation or Supination or Both |
| ☐ | Dynamic Pro/Sup | Right or Left or Both | E1802 | Pronation or Supination or Both |
| ☐ | JAS EZ Wrist | Right or Left or Both | L3905 | Flexion or Extension or Both |
| ☐ | Dynamic Wrist | Right or Left or Both | E1805 | Flexion or Extension or Both |
| ☐ | JAS EZ Knee | Right or Left or Both | L1844 | Flexion or Extension or Both |
| ☐ | Dynamic Knee | Right or Left or Both | E1810 | Flexion or Extension or Both |
| ☐ | JAS EZ Ankle | Right or Left or Both | L1970 | |
| ☐ | Dynamic Ankle | Right or Left or Both | E1815 | |
| ☐ | JAS EZ Shoulder | Right or Left or Both | L3973 | |
| ☐ | JAS EZ Finger | | L3935 | Flexion or Extension or Both |
| ☐ | JAS EZ Toe | | E1399 | Flexion or Extension or Both |

## DIAGNOSIS

**Primary ICD10 Numeric Code:**_____ **Secondary ICD10 Numeric Code:**_____

## PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

*By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to The current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.*

**Physician Name**_____ **NPI#**_____ **Phone**_____ **Fax**_____

**Physician Address**_____ **City**_____ **State**_____ **Zip**_____

**Physician Signature**_____ **Date Signed**_____