



Active Medical

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www.activemedical2u.com

DETAILED WRITTEN ORDER

PATIENT NAME _____ D.O.B. _____

HEIGHT _____ WEIGHT _____ DX _____ L.O.N. _____ 99=LIFE

EQUIPMENT KNEE

___ OA KNEE BRACE L1812/L2795 ___ R ___ L

___ HINGED KNEE BRACE L1832 ___ R ___ L

___ PLAYMAKER KNEE BRACE L1833 ___ R ___ L

EQUIPMENT FOOT/ANKLE

___ NIGHT SPLINT L4396 ___ R ___ L

___ WALKING BOOT L4361 ___ R ___ L

___ ACCORD ANKLE BRACE L1971 ___ R ___ L

___ LACE UP ANKLE BRACE L1902 ___ R ___ L

___ EVALUATE/TREAT CUSTOM AFO ___ R ___ L

EQUIPMENT HAND/WRIST

___ WRIST SPLINT L3908 ___ R ___ L

___ WRIST SPLINT W/THUMB SPICA L3908 ___ R ___ L

___ OTHER _____ ___ R ___ L

PHYSICIAN PRINTED NAME _____ NPI _____

SIGNATURE _____ DATE _____

*Please fax Detailed Written Order, Patient Demographic Information, Patient Insurance Information, and most recent Notes relative to the diagnoses to ACTIVE MEDICAL 855-244-3350. THANK YOU!