Printed on :

Patient Information

Personal Information

First Name		**Middle Name**	
Last Name		**D.O.B**	
Gender		**Address**	
City		**State**	
Cell Phone #		**Home Phone**	
Work		**Zip**	
Email		**Extn.**	
Attorney		**Case Type**	
Attorney Address		**Attorney Phone**	
Case Status		**SSN**	

Insurance Information

Policy Holder		**Name**	
Address		**City**	
State		**Zip**	
Phone		**Fax**	
Contact Person		**Claim File #**	
Policy #			

Accident Information

Accident Date		**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission		**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information

Name		**Phone**	
Extension		**Fax**	
Email			

PRESCRIPTION/ LETTER OF MEDICAL NECESSITY

PATIENT INFO:

_____ _____

PATIENT NAME **SURGERY DATE**

_____

DIAGNOSIS CODES

EQUIPENT PRESCRIBED:

CONTINUOUS PASSIVE MOTION DEVICE (CPM)

PART OF THE BODY:

	KNEE	**RIGHT**	**LEFT**		**ANKLE**	**RIGHT**	**LEFT**
X	**SHOULDER**	x **RIGHT**	**LEFT**		**WRIST**	**RIGHT**	**LEFT**
	OTHER _____						

4-6 weeks

DURATION

SPECIAL INSTRUCTIONS

MEDICAL NECESSITY REASONING:

I am prescribing CPM (Continuous Passive Motion) that will help my patient during the post-operative recovery by increasing range of motion, preventing the development of motion-limiting adhesions, decreasing soft tissue stiffness and stimulating healing of joint surfaces and soft tissues. Moreover, the prescribed CPM Device will involve movement of the joints without active contraction of muscle groups and without patient effort, in view of the fact that, active movement that might destabilize the recovery and, also cause a painful process. Inasmuch, using CPM Device, my patient will experience less pain, recover faster, and, consequently there will be less pain medication and physical therapy required.

Physician Signature: _____

Physician Name: _Dr. Upendra Sinha_____

License Number: __1063520336_____

Address: _102-31 Jamaica Ave., Richmond Hill, NY 11418_

TEL: _718-480-1130_____

PRESCRIPTION/ LETTER OF MEDICAL NECESSITY

PATIENT INFO:

_____ _____

PATIENT NAME **SURGERY DATE**

_____

DIAGNOSIS CODES

EQUIPENT PRESCRIBED:

COLD THERAPY CIRCULATING PUMP/GR

PART OF THE BODY:

	KNEE	**RIGHT**	**LEFT**	**ANKLE**		**RIGHT**	**LEFT**
X	**SHOULDER**	X **RIGHT**	**LEFT**	**WRIST**		**RIGHT**	**__LEFT**
	OTHER _____						

2-4 weeks

_____

DURATION

_____

SPECIAL INSTRUCTIONS

MEDICAL NECESSITY REASONING:

I am prescribing Cold Therapy Circulating Pump/GR, as this device is medically necessary and reasonable in reference to my patient's post-operative recovery. This pneumatic cold compression therapy system will provide my patient adjustable cold and intermittent compression. Insofar as it is a proven and effective technique in post-operative recovery. Respectively,the Cold Therapy Unit will productively reduce recovery time as well as reducing swelling,edema and pain. By delivering comprehensive, flexible, and proven treatment of swelling, edema, pain or/and other post-surgical or injury conditions, I consider that my patient's rehabilitation process will be highly alleviated.

Physician Signature: _____

Physician Name: _Dr. Upendra Sinha_____

License Number: ___1063520336_____

Address: _102-31 Jamaica Ave., Richmond Hill, NY 11418_

TEL: _718-480-1130_____