## ORTHOTIC DEVICE NEED ASSESSMENT

EXAM DATE: ##ServiceDate##

**CHIEF COMPLAINT**

The patient complains of \_##PainChart##\_ pain at the time of this assessment.

## VITALS

Height: \_##height##\_

Weight: \_##Weight##\_ lbs. Shoe Size : \_##ShoeSize##\_

Waist Size: \_##Waist##\_ inches DOB: \_\_\_\_##Dob##\_\_\_\_\_\_

# Dr. Colleen Browne NPI: 1780777482 DEA: BL5818969

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## SUBJECTIVE

The patient describes their \_##PainChart##\_ pain to be at a level of \_##PainLevel##\_ on a 0 to 10 scale. The patient describes the duration of the pain as \_##PainDuration##\_. The etiology of the patient's \_##PainChart##\_ pain is described by patient as \_##PainFeeling##\_ . Conditions that cause or aggravate the \_##PainChart##\_ pain include \_##PainCause##\_. Previously, the patient has tried \_##PainSelfTreatment##\_, with limited success. When asked whether it eﬀects activities of daily living, the patient stated \_##EffectsDaily##\_.

## RELATED SURGERY

The patient states, they had \_##Surgies##\_ surgeries in the area of \_##PainChart##\_

## OBJECTIVE/ASSESSMENT

Patient name, \_##PatientName##\_, a \_##Gender##\_, currently \_##Age##\_ years old and weighs \_##Weight##\_lbs. The patient claims their pain was initially caused by \_##PainFeeling## . Treatments previously tried for \_##PainChart##\_ pain include \_##PainSelfTreatment##\_. When asked about previous surgery, the patients response was \_##Surgies##\_. Conditions that cause or aggravate the patients \_##PainChart##\_ pain include \_##PainCause##\_. The condition necessitating the Back Brace is expected to be permanent or of 6 months or more duration and there is a need to control the \_##PainChart##\_ pain in more than one plane. Adjustments and assistance with ﬁtting and sizing will not be required for the Back Brace . The Back Brace is prescribed for the following indication(s); the patient is ambulatory and has weakness of the \_##PainChart##\_ pain that requires stabilization and has the potential to beneﬁt the patient functionally.

## DIAGNOSIS:

Lower Back pain m51.37 other intervertebral disc degeneration, lumbosacral region, m54.5 low back pain, g89.4 chronic pain, .

## PLAN AND TREATMENT GOALS

Based on my clinical impression with \_##PatientName##\_ and evaluation of their condition, I am ordering the following for the \_##PainChart##\_: Back Brace - L0650 (Lumbar-sacral orthosis. Sagittal control with rigid anterior and posterior panels, posterior panels, posterior extends from Sacrococcygeal junction to the T-9 vertebra, lateral strength, with rigid lateral panels, prefabricated and oﬀ the shelf. Custom ﬁtting of the orthosis is not required and the patient or an assisting care giver can apply the prescribed orthotic device with minimal self- adjusting.) , the patient has been advised to use the device for support of their Lower Back pain as needed for comfort; or daily if necessary, to provide support to the area and aid potentially weak musculature and to improve activities of daily living.

## THE INDICATIONS OF NEED:

\_##PainChart##\_: The patient is ambulatory and has pain, discomfort and weakness in the region that requires stabilization and has the potential to beneﬁt functionally, by aiding and supporting the musculoskeletal unstable or weak area.

I believe the L0650 will beneﬁt \_##PatientName##\_ by helping to reduce pain by restricting mobility of the trunk.

## TREATMENT GOALS:

\_##PainChart##\_ pain: Improvement in patient’s function. Improvement in patient’s pain. Increase performance in activities of daily living. Reduce medications. Slow musculoskeletal degeneration. Reduce inﬂammation.

Custom ﬁtting of the orthosis is not required and the patient or an assisting caregiver can apply the prescribed orthotic device with minimal self-

Our telephone number has been provided to \_##PatientName##\_ in case there are follow up questions for his use and/or adjustment directions from our oﬃces. I have also recommended for the patient to speak with their primary care Physician in the near future as part of their ongoing plan of care.

I, Dr. Colleen Browne, verify and conﬁrm this order for the above-named patient, and certify that I have personally performed the assessment of the patient for the prescribed treatment and device and verify that it is reasonably and medically necessary, according to accepted standards of medical practice within the community, for this patient’s medical condition.

Electronically Signed and Dated: Wednesday, April 17, 2019 03:07:20 PM. Colleen Browne, NPI: 1780777482



*04/17/2019*

From IP Address: 71.227.14.16

Colleen Browne