**Patient Information** Patient: \_1\_ Address: \_2\_ Phone: \_3\_

Weight: \_5\_ lbs.

Height: \_4\_ Shoe Size: 11Age: \_6\_ Years

DOB: \_\_

Gender: \_8\_

# ------Detailed Written Order------

**Date of Service: 24**

**Dr. Colleen Browne NPI: 1780777482 DEA: BL5818969**

**9343 Butler Road Portland, MI 48875**

**Phone: 5179743560**

**Fax:**

**DIAGNOSIS**

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

# STATEMENT OF MEDICAL NECESSITY

The orthotic device or devices ordered as of the result of this examination is being prescribed as adjunctive therapy to assist in reducing the level of pain and symptoms associated with the patient’s identiﬁed diagnosis, and for overall improvement in the patient’s quality of life.

# PREVIOUSLY TRIED TREATMENTS

\_17\_

# PAIN LEVEL DESCRIBED BY PATIENT

\_23\_ on a 0-10 scale

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. I hereby aﬃrm this documentation as part of this patient’s medical record.

# Insurance Information

Member ID: \_\_\_\_\_\_\_\_

Insurance Type: Medicare or Private

# ORTHOSIS DEVICE(S) PRESCRIBED

Based on my examination of this patient, I am ordering the following orthosis for the Lower Back:

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.)

Patient should begin using the orthosis as needed. Length of need:

# 99 months/lifetime.

First date patient is authorized to begin using Back Brace : 24

# My treatment goal(s) for the use of the prescribed orthosis are:

* Support weak musculature
* Improvement in Patient’s function
* Decrease in Patient’s pain
* To assist the patient or improve activities of daily living
* To aid in the stabilization of the Lower Back
* To aid in controlling unwanted movements in the area of pain
* Slow degenerative changes
* Reduce potential inﬂammation

# Additional Doctor Notes:

Thoroughly reviewed all available medical information on record and listened to survey recording. Contacted patient today, 24, today for further evaluation and remote examination. Patient advised to f/u with PCP regarding this and other ongoing medical issues. Consultant's n/n provided for future reference, as needed. Patient with understanding of and agreement with plan of care. cdb. 24.

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



*24*

From IP Address: 71.227.14.16

Colleen Browne