



113 PRODUCTION DR. SUITE 2 SLIDELL, LA 70460
OFFICE: 985.649.3019 FAX: 985.643.0422

PHYSICIAN'S ORDER

PATIENTS NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ DOB: _____ SEX: M F

DIAGNOSIS: _____

ICD-10 CODE: _____

LENGTH OF NEED: MONTHS _____ LIFETIME (99) _____

LAST FACE-TO-FACE DATE: _____

MEDICAL RECORDS INCLUDED: YES NO

WEIGHT: _____ HEIGHT: _____

REASON FOR NEED/MEDICAL NECESSITY:

SPECIFIC SUPPLIES ORDERED:

The undersigned, certify that the above prescribed equipment/supplies is medically necessary as part of my treatment for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards for medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment".

PHYSICIANS NAME & ADDRESS:

PHYSICIAN SIGNATURE:

NPI: _____

DATE: _____

PHONE: _____

FAX: _____