D&J Medical
ORTHOTICS PROSTHETICS COMPRESSION

Maryland Orthotics & Prosthetics
A D&J MEDICAL COMPANY

Locations

HARFORD COUNTY OFFICE
8 Newport Drive
Forest Hill, MD 21050
410.893.1116 *office*
410.420.2773 *fax*

TOWSON OFFICE
GBMC
6569 North Charles Street
Physician's Pavilion West, Suite 705
Baltimore, MD 21204
443.617.1090 *office*
443.773.0423 *fax*

BALTIMORE OFFICES
301 St. Paul Place
Baltimore, MD 21202
410.659.2831 *office*
410.951.7962 *fax*

8517 Loch Raven Boulevard
Baltimore, MD 21286
410.665.8200 *office*
410.665.2401 *fax*

HOWARD COUNTY OFFICE
10772 Hickory Ridge Road
Columbia, MD 21044
410.561.6227 *office*
443.451.8625 *fax*

CARROLL COUNTY OFFICE
15 East Main Street, Suite 116
Westminster, MD 21157
410.876.6584 *office*
410.665.2401 *fax*

Hours

Monday – Friday, 9 am to 5 pm
Baltimore Office: 8:30 am - 4:30 pm
Westminster: Limited Hours

Please call for an appointment

Fax Cover Sheet - Prosthetic Request

Date: _____

To: _____ Fax#: _____

From: _____ Phone: _____

Number of pages _____ *(including cover sheet)*

Dear Doctor,

Our office was recently contacted by one of your patients with a request to complete an evaluation and provide a prosthetic device to aid and assist in their activities of daily living. A copy of the practitioner's evaluation is included in this fax.

The device recommended for your consideration is:

_____

As noted in Medicare's Guidelines (and other insurances), in addition to a prescription, the patient's physician treatment notes are also required for coverage of this device. According to the Medicare Guidelines, the Physician treatment notes must include: Patient name, DOB, Date of amputation, Type of amputation, Type of prosthesis, the K-Level of the patient, as how this device will improve the patient's activities of daily living.

This treatment note is also required to be produced after a face to face encounter with the patient. Realizing that most physicians are unaware of this requirement, we have formulated a Physician Treatment Note template. This template addresses all Medicare requirements for a prosthesis. The treatment note can be included into your patient file or the data can be incorporated into your treatment note format. We have also placed this note in a writable PDF file version. Please remember this is a Medicare requirement.

We have included a copy of the treatment note or you can retrieve a PDF version on the Resources page of our website: dandjmedical.com/helpful-links

Please FAX the prescription and completed treatment note to 410.343.9876

Thank you, D&J Medical and MDOP

Physician Prescription for Prosthesis

Physician: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Patient Name: _____ **DOB:** _____

(Please circle appropriate level of amputation)

UPPER EXTREMITY Right / Left

☐ Above Elbow (AEA) ☐ Below Elbow (BEA) ☐ Wrist ☐ Finger

LOWER EXTREMITY Right / Left

☐ Above Knee (AKA) ☐ Below Knee (BKA) ☐ Symmes ☐ Trans Metatarsal (Partial Foot)

_____ Evaluate and design/fit

Physician Signature: _____ Date: _____

Physician Name (printed): _____

NPI: _____

Please FAX completed prescription to:

FAX #: _____

Physician Treatment Notes

Physician: _____ Date: _____

Patient First Name: _____ Last Name: _____

DOB: _____ Height: _____ Weight: _____ Male / Female

History of Present Condition: *(History of present condition(s) and past medical history that is relevant to functional capabilities)*

_____

_____

_____

Date of Amputation: _____ Side of Amputation: ☐ Right ☐ Left

Type of Amputation: ☐ Trans Met ☐ Symes ☐ BK ☐ AK ☐ Other: _____

Description of Residual Limb: ☐ Sutures ☐ Staples Still in Place ☐ Non-closure of Surgical Site
☐ Complete Healing of Surgical Site ☐ Other: _____

Clinical Course: ☐ Patient in Hospital ☐ Patient in Inpatient Rehabilitation ☐ Patient at Home

Therapeutic Interventions: ☐ Yes ☐ No *If yes, what type:* ☐ PT ☐ OT ☐ Home Health Care

Examination of Cardiopulmonary/Musculoskeletal/Neurological: *(Are there any finding that would limit patients' ability to use device?)*

_____

MUSCULOSKELETAL EXAMINATION

Arm Strength: ☐ Good ☐ Poor ☐ Need for Therapeutic Intervention

Leg Strength: ☐ Good ☐ Poor ☐ Need for Therapeutic Intervention

Upper Extremity ROM: ☐ Good ☐ Limited ☐ Poor ☐ Need for Therapeutic Intervention

Lower Extremity ROM: ☐ Good ☐ Limited ☐ Poor ☐ Need for Therapeutic Intervention

NEUROLOGICAL EXAMINATION

Gait: ☐ Good ☐ Limited ☐ Poor ☐ Need for Therapeutic Intervention

Balance and Coordination: ☐ Good ☐ Limited ☐ Poor ☐ Need for Therapeutic Intervention

Are there Limitations of Patients ADL's: ☐ Yes ☐ No

If yes, what limitations: ☐ Self-care ☐ Home Activities (such as cooking & cleaning) ☐ Care of Dependents

ADL's: ☐ Cooking ☐ Cleaning ☐ Work ☐ Hobbies ☐ Walking (Exercise) ☐ Other: _____

Ambulatory Assistance Used: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other: _____

How Long Before Patient is Free of Assistance Device: ☐ Upon Receiving and Training with Prosthetic Device
☐ Upon Health Restoration ☐ Other: _____

_____

Physician Treatment Notes

Patient First Name: _____ Last Name: _____

Functional Level Prior to Amputation: ☐ No Restrictions Prior to Amputation ☐ Other: _____
☐ Limitations prior to Amputation Due to Disease that Necessitated Amputation

Patients Current Activities: ☐ Severe Limitations ☐ Moderate Limitations ☐ Marginal Limitations
☐ No Limitations ☐ Other: _____

Desired and Potential Activities with a Prosthesis: ☐ Return of Pre-amputation ADL's ☐ Work ☐ Return to Home
☐ Dependent Care ☐ Other: _____

Current Prosthesis: ☐ Yes ☐ No

Reason for Prosthesis: ☐ New Amputee ☐ Volume Change ☐ Irreparable Damage ☐ Other: _____

(*If patient already uses prosthesis please identify the reason for Replacement of Prosthesis or Major Component (foot, ankle, knee, socket/suspension component*))

The following item(s) must be replaced: ☐ Foot ☐ Ankle ☐ Knee
☐ Socket/Suspension Component ☐ Entire Prosthesis

Reason for Replacement: ☐ Change in Physiological Condition of the Patient ☐ Irreparable Wear ☐ Prosthesis was Lost
☐ Prosthesis was Damaged ☐ Cost of Repairs Would be More Than 60% of the Cost of a Complete Replacement
☐ Other: _____

Patients' Desire and Motivation to Ambulate: ☐ Strong ☐ Moderate ☐ Medium ☐ None

FUNCTIONAL LEVEL:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of a limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces typical of the limited community ambulator.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of a community ambulator who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise ability that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of a child, active adult, or athlete.

Patient Will Reach or Maintain a Defined Functional State Within a Reasonable Period of Time: ☐ Yes ☐ No

_____

Patient is Motivated to Ambulate: ☐ Yes ☐ No _____

Physician Treatment Notes

Patient First Name: _____ Last Name: _____

Additional: _____

This patient and I met face-to-face for _____ minutes.

Physician Signature: _____ Date: _____

Physician Name (printed): _____

NPI: _____

Physician Treatment Notes

Physician: _____ Date: _____

Patient First Name: _____ Last Name: _____

DOB: _____ Height: _____ Weight: _____ Male / Female

History of Present Condition: *(History of present condition(s) and past medical history that is relevant to functional capabilities)*

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Additional: _____

_____

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Physician Name (printed): _____

NPI: _____