



Therapy Station

AUTHORIZATION FOR SPLINT / ORTHOSIS

PATIENT NAME _____	DOB _____
DIAGNOSIS _____	EFFECTIVE DATE _____
INSURANCE _____	POLICY NUMBER _____
CURRENT SPLINT / ORTHOSIS _____	
CURRENT WEARING SCHEDULE _____	
REASON FOR NEW ORTHOSIS _____	

SPLINT / ORTHOSIS RECOMMENDATIONS

GOALS: *(Check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Increase independence with ADL's | <input type="checkbox"/> Maximize ROM in UE / LE |
| <input type="checkbox"/> Increase Safety | <input type="checkbox"/> Increase Hygiene |
| <input type="checkbox"/> Facilitate motor control and tone in UE / LE | <input type="checkbox"/> Minimize contractures |
| <input type="checkbox"/> Promote postural control / standing balance / Activity tolerance | <input type="checkbox"/> Increase functional transfers |

Wearing schedule: _____

- | | |
|---|---|
| <input type="checkbox"/> During walking | <input type="checkbox"/> As tolerated |
| <input type="checkbox"/> During night | <input type="checkbox"/> Eight hours every twelve hours |

Physician Instruction on precautions _____

I CERTIFY THAT THE ABOVE RECOMMENDED SPLINT / ORTHOSIS IS MEDICALLY NECESSARY AND VALID.

Physician Signature: _____ Medipass Authorization Number: _____

Physician Name: _____ Date: _____

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