

STEP 1: Fill Out ^{Rx}

Patient:

Name _____
Address _____

Tel (_____) _____

Referring Physician:

Name _____
Address _____

Tel (_____) _____

Diagnosis _____ ICD 10 CODE _____
Surgical Procedure _____ D.O.S. _____

STEP 2: Select

LOWER EXTREMITY: LEFT RIGHT BILATERAL



Arizona AFO



Custom Richie Style AFO



Crow Boot



ASO Ankle Brace



Cam Boot
 Short
 Tall



Bone Growth Stimulator



Custom AFO

COMMENTS:

Custom Foot Orthotics



COMMENTS:

Game Ready® Ankle Wrap



OTHER: (Please Specify)

STEP 3: Sign/Date

_____, M.D.
D.A.W. – Physician Signature
Date _____

STEP 4: Fax

Fax completed form, patient's demographics and all insurance information to:

1-800-866-8011