ADVANCED
Home Medical, Inc.

312 Paseo Tesoro ♣ Walnut CA 91789
**Customer Service: 1-800-230-4761**

# IL and MI DOCTOR'S ORDER FORM (Rx) - MATERNITY ORTHOTICS

**Patient Information:** **Ship to: ❑ Home ❑ Clinic ATTN: _____**

Patient Name: _____ Phone: _____

Address:_____Apt:_____City/State:_____ Zip:_____

Insurance (attach copy): ❑ Medicaid ID#: _____ DOB:_____

Ht:_____ Pre-pregnancy Wt:_____ lbs Pregnancy-related?: Y N Due / Delivery Date:_____

## ❑ Lumbar Support Belt (Qty: 1)

Dx:
- ❑ Low back pain (M54.50)
- ❑ Pelvic pain (R10.20)
- ❑ Other _____
- ❑ Hip pain (M25.559)
- ❑ Upper back pain (M99.02)
- ❑ Spasm, tension, pain (M35.7)

Size (circum. midway bet. hips & waist):
- ❑ Small (28"-33")
- ❑ Medium (33"-38")
- ❑ Large (38"-41")
- ❑ XL (41"-46")
- ❑ 2XL (46"-51")

## ❑ Perineal V2 Support (Qty: 1)

Dx:
- ❑ Vulvar varicosities (I86.3)
- ❑ Perineal edema (I83.899)

**Hip Measurement (inches):**
- ❑ Petite (24-29)
- ❑ Small (28-33)
- ❑ Medium (32-37)
- ❑ Large (37-42)

## ❑ Hernia Guard, double (Qty:1)

Dx:
- ❑ Inguinal Hernia (low profile)
- ❑ Umbilical Hernia

**Waist:_____ inches**

## ❑ Elastic Stockings (18-30 mmHg)

Diagnosis:
- ❑ Edema / Swelling (R60.1)
- ❑ Varicose Veins (I83.90)
- ❑ Venous Insufficiency (I87.2)
- ❑ Other _____

**Quantity (circle): 1 2 pairs**

Style/Type:
- ❑ Below Knee
- ❑ Above Knee / Thigh
- ❑ Pantyhose
- ❑ Maternity Pantyhose

| Ankle Size: | | Calf Size: |
|---|---|---|
| ❑ 7"-8.25" | S | ❑ 11"-15" |
| ❑ 8.25"-9.5" | M | ❑ 11.75"-16.5" |
| ❑ 9.5"-10.75" | L | ❑ 12.5"-18" |
| ❑ 10.75"-12" | XL | ❑ 13"-19" |
| ❑ 12"-13.25" | XXL | ❑ 13.5"-20" |

## ❑ Wrist Splint (universal)

Dx: ❑ Wrist Pain [ ] M25.532 [ ] M25.531 **Circle: L R**
❑ Carpal Tunnel Syndrome ❑ RT (G56.01) ❑ LT (G56.02) ❑ BI (G56.03)

## ❑ Blood Pressure Kit, Auto (Qty: 1)

Dx:
- ❑ Hypertension (I10)
- ❑ Other:_____

## ❑ Hip Brace / S.I. Belt (Qty: 1)

Dx:
- ❑ Pubic symphisis separation (O71.6)
- ❑ Pelvic joint pain (M25.559)
- ❑ Other:_____

Size (HIP measurment in inches):
- ❑ Petite (24"-32")
- ❑ Small (32"-40")
- ❑ M (40"-48")
- ❑ L (48"-56")

## ❑ Abdominal Binder (Qty: 1)

Dx:
- ❑ Pendulous Abdomen (L91.9)
- ❑ C-Section (O82)

Waist Size (pre-preg) _____ inches

## ❑ Electric breast pump (Qty: 1)

Dx:
- ❑ Lactation (Z39.1)
- ❑ Engorgement (O92.29)

DECLARATION: I certify that this is true and medically necessary for the above patient. I have completely reviewed my patient's medical records and the items ordered. I understand that any falsification, omission, concealment of material fact may be subject to civil or criminal liability.

**Provider Signature** _____ Date: _____

## Provider Name & Address:

❑ Full Name_____

NPI _____

Street Address _____

City _____ State ____ Zip _____

Contact _____ Phone _____

**PLEASE FAX TO: 1-888-518-7568**

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