

DETAILED WRITTEN ORDER
PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY (CMN)

PATIENT INFORMATION:				DATE OF ORDER:	
Last Name	First Name	Middle Initial	Gender	Date of Birth	
Address		City		State	Zip Code
Phone #	Office Use:				
PRIMARY INSURANCE: Member ID:			Group #		
Secondary Insurance Company	Member ID		Group #		

PRODUCT CODE	DESCRIPTION	(CHECK)	RIGHT	LEFT	BOTH	QTY
L1833	KCO KNEE BRACE (Prefab KCO, OTS)	<input type="checkbox"/>	___	___	___	___

DIAGNOSIS(es) [ICD-10]: <i>(Please check at least one)</i>	<input type="checkbox"/> M17.11, M17.12 UNILATERAL OSTEOARTHRITIS; Specify R or L _____ <input type="checkbox"/> M17.0 BILATERAL OSTEOARTHRITIS <input type="checkbox"/> M06.861, M06.862 RHEUMATOID ARTHRITIS; Specify R or L <input type="checkbox"/> ADDT'L DIAGNOSIS: _____
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CERTIFICATE OF MEDICAL NECESSITY: <i>(Please check at least one)</i>	<input type="checkbox"/> TO REDUCE PAIN BY RESTRICTING MOBILITY OF THE KNEE; <input type="checkbox"/> TO FACILITATE HEALING FOLLOWING AN INJURY TO THE KNEE OR RELATED SOFT TISSUE; <input type="checkbox"/> TO FACILITATE HEALING FOLLOWING A SURGICAL PROCEDURE ON THE KNEE OR RELATED SOFT TISSUE; <input type="checkbox"/> TO OTHERWISE SUPPORT WEAK KNEE JOINT AND/OR DEFORMED KNEE
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I understand that I am prescribing the above item(s), for the period(s) indicated, due to patient's needs and diagnosis(es).
 I certify that the above item(s) is/are medically necessary for the patient's functional restoration: Is/are reasonable, medically necessary and not a convenience item(s); and that I am the attending physician.

Physician Name	Phone #	Fax #	
Address	City	State	Zip Code
Physician Signature	Date Signed	NPI #	

Regenesys - St. John's Medical
 1704 Southside Blvd. Suite 2
 Jacksonville, FL 32216
 Phone: 1-904-783-9363



RETURN FAX: 1-888-430-8776

ALTERNATIVE FAX: 904-783-0995

PATIENT CONSULTATION SUMMARY - CHART NOTES

DATE:

PATIENT LAST NAME	PATIENT FIRST NAME	DOB	AGE	GENDER
PHYSICIAN		PATIENT CHIEF COMPLAINT	PT WEIGHT	PT HEIGHT

PATIENT HISTORY

VISIT NOTES:

ALLERGIES:

<u>NAME</u>	<u>REACTION</u>

MEDICATIONS:

<u>NAME</u>	<u>CURRENT</u>	<u>DATE STARTED</u>	<u>DATE ENDED</u>	<u>FREQUENCY</u>	<u>DOSAGE</u>

DIAGNOSIS/IMPRESSION:

PLAN:

PRESCRIBED MEDICINE:			ADDITIONAL REQUESTED DIAGNOSTICS:
<u>NAME</u>	<u>DOSAGE</u>	<u>INSTRUCTIONS</u>	

PHYSICIAN SIGNATURE:	DATE: