Bio DYNAMIC TECHNOLOGIES

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STEP 1: Fill Out ℞

Patient:

Name _____

Address _____

_____

Tel (_____) _____

Referring Physician:

Name _____

Address _____

_____

Tel (_____) _____

Diagnosis _____ ICD 10 CODE _____

Surgical Procedure _____ D.O.S. _____

STEP 2: Select

UPPER EXTREMITY ❑ **LEFT** ❑ **RIGHT** ❑ **BILATERAL**

☐ Cock-Up Wrist Brace

☐ Thumb Spica

☐ Range of Motion Elbow Brace

Range of motion: _____

☐ Mayo Clinic Progressive Stretching Elbow Brace

Range of motion: _____

☐ Shoulder Abduction Sling with Pillow

☐ Shoulder Abduction Sling with Moldable Waist

☐ Upper Extremity Bone Stim Unit

☐ Hand/Wrist Bone Growth Stimulator

☐ Humeral Fracture Brace

☐ Game Ready® Cold Therapy Elbow Wrap

☐ Game Ready® Cold Therapy Shoulder Wrap

☐ Game Ready® Cold Therapy Hand Wrap

OTHER:

_____

_____

_____

_____

_____

_____

_____

_____

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