REHAB SERVICES, LLC

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Physician Order, Prescription and Certificate of Medical Necessity

Patient Name:_____ Date of Order:_____

Patient Phone Number(s):_____

Date of Surgery:_____ Anticipated Discharge:_____

Type of CPM: KNEE SHOULDER ELBOW ANKLE

Side: Left Right

Primary Diagnosis Code or Description:_____

_____

Initial Settings / Goal:_____

_____

Duration of Medical Necessity:

2 weeks 3 weeks 4 weeks 6 weeks Other_____

By signing below, I deem this Continuous Passive Motion Machine to be medically necessary and prescribe it to be provided at home for the patient listed above.

Physicians Signature:_____ Date:_____

Physicians Printed Name:_____

NOTES:_____
_____
_____

Please include Patient Demographic Sheet and fax to Rehab Services, LLC at 410.691.0035