WRIGHT ORTHOTICS &PROSTHETICS

PHONE: 512-593-6635
FAX: 512-265-9020

PATIENT NAME: _____ DOB: _____

PHONE NUMBER: _____ SEX: _____ RX DATE: _____

DIAGNOSIS: _____

Rx

ORTHOSIS		PROSTHESIS	SIDE
☐ FOOT	☐ SPINAL	☐ TRANSTIBIAL	☐ LEFT
☐ ANKLE FOOT	☐ CRANIAL	☐ TRANSFEMORAL	☐ RIGHT
☐ KNEE ANKLE FOOT	☐ UPPER LIMB	☐ UPPER LIMB	☐ BILATERAL

DETAILS:

I AFFIRM THAT THE TREATMENT PLAN DESCRIBED ABOVE IS MEDICALLY NECESSARY FOR THIS PATIENT AND AUTHORIZE WRIGHT ORTHOTICS AND PROSTHETICS TO PROVIDE RELATED CARE.

PHYSICIAN SIGNATURE: _____

PHYSICIAN NAME: _____

NPI: _____ DATE: _____

PLEASE SIGN AND FAX TO 512-265-9020

BASTROP
1106 COLLEGE ST, STE D
BASTROP, TX 78602

ALL CARE THERAPIES
OF GEORGETOWN
3610 WILLIAMS DR
GEORGETOWN, TX 78628

SOUTH AUSTIN
5200 DAVIS LN, #B210
AUSTIN, TX 78749