OPA Orthotic & Prosthetic Associates

TAX ID 76-0588783

Bellaire Office - 5420 West Loop S., Suite 1200 • Bellaire, TX 77401 • Phone: 713-660-8801 • Fax: 713-660-8809
Katy Office - 21700 Kingsland Blvd., Suite 107 • Katy, TX 77450 • Phone: 281-578-4810 • Fax: 281-578-4813
Conroe Office - 100 Medical Center Blvd., Suite 116 • Conroe, TX 77304 • Phone: 936-441-0330 • Fax: 936-441-0336

Patient Name _____ *Date of Birth* _____ *Current Date* _____

Phone _____ *Address* _____

Diagnosis _____

℞

Start Date: _____

☐ CUSTOM BRACE(S)	☐ OFF–THE–SHELF BRACE(S)
To be evaluated and measured/molded for custom Orthotic(s) A pre-fabricated device will not address the needs of this patient.	*For best outcome, the prescribed pre-fabricated device and/or supply is to be evaluated for and custom fit by a licensed Orthotist to assure appropriate fit and function, perform necessary adjustments, molding or trimming and to provide wear and care instructions as well as any follow-up needs.*
☐ PROSTHETIC(S)	☐ SHOES ☐ INSERTS ☐ SUPPLIES

Physicians: If selecting pre-fabricated, off-the-shelf devices, please check the above box indicating that a qualified individual is necessary in your patient's care. Coding requirements effective January 1, 2014 indicate that documentation must exist in your patient record.

PROGNOSIS: ☐ *Poor* ☐ *Fair* ☐ *Good* ☐ *Excellent*

DURATION OF NEED: ☐ *2 Weeks* ☐ *4 Weeks* ☐ *90 Days* ☐ *6 Months* ☐ *1 Year* ☐ *Lifetime*

The item prescribed is medically necessary for the patient's daily function and/or stabilization and healing.

(Physician Stamped Demographics and NPI)

Physician's Signature (Stamped signature not valid) _____ Date _____

Physician's Name (Printed) _____ NPI # _____

Address _____ Telephone _____

City, State, Zip _____ Fax _____