

# Prescription Form

## Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Length of Need: \_\_\_\_\_ years (99 for lifetime)

Device Prescribed: Elbow-Wrist-Hand-Finger Orthosis, Motion G

## Description of Device

**L8702**      Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories custom fabricated

## Prescriber Information

Name: \_\_\_\_\_ NPI #: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Order Date: \_\_\_\_\_