TELA MEDICAL
MEDICAL EQUIPMENT SOLUTIONS

PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY

Compression Orthosis

Patient Name_____

Diagnosis_____

Surgical_____ **Non-Surgical**_____

Knee: Left/Right Back: High/ Low Shoulder: Left/ Right

Hip: Left/ Right Elbow: Left/ Right Wrist: Left/ Right

In my evaluation this patient has clinical findings that verify that a compression orthosis is medically necessary to facilitate management of this patient's diagnosis according to the current accepted standards of practice.

I certify that the above described product is medically necessary and recommend that the patient use this device daily.

Physicians Name (PRINT)_____

Telephone_____

Address_____

City_____ State_____ Zip_____

Physicians Signature_____ Date_____

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