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TELA MEDICAL
MEDICAL EQUIPMENT SOLUTIONS

Good for the Patient. Good for the Practice.

PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY

Patient Name_____

ICD 10 Diagnosis_____

Surgery Date_____ **Non-Surgical**_____

Knee: Left/Right Shoulder: Left/ Right Back

Foot/Ankle: Left/ Right Arm/Elbow/Wrist/Hand: Left/ Right Cervical

Equipment Prescribed

Vasopneumatic Cold Compression Device with Pneumatic Wrap(s)

Rental Length of Need (Circle one) 1 week 2 weeks 3 weeks 4 weeks Other_____

Continuous Passive Motion (CPM) Device with Soft Good(s)

Rental Length of Need (Circle one) 1 week 2 weeks 3 weeks 4 weeks Other_____

Initial Settings/Goals_____

Deep Vein Thrombosis (DVT) Prophylaxis Device with Pneumatic Wrap(s)

Rental Length of Need (Circle one) 1 week 2 weeks 3 weeks 4 weeks Other_____

In my evaluation this patient has clinical findings that verify that a cold compression device with pneumatic wraps and/or a CPM machine and/or DVT is medically necessary to facilitate management of this patient's diagnosis according to the current accepted standards of practice.

The vasopneumatic cold compression therapy system combines cold and compression therapies. It is intended to treat acute injuries, persistent injuries and the post-surgical patient. Cold pneumatic compression therapy helps reduce edema, swelling, pain, muscle spasms and helps accelerate the healing process. The cyclical pneumatic compression technology limits swelling and helps remove swelling by forcing tissue debris and fluid into the lymphatic system. Due to the local anesthetic value of this product, narcotics use and subsequent rehabilitation costs are reduced. Failure to control pain on a daily basis causes unnecessary suffering and delayed recovery.

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_____